Updated: 07/2020
DMMA Approved: 08/2020

Request for Prior Authorization for Tobramycin Inhalation Products
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Tobramycin Inhalation Products require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Tobramycin Inhalation Products Prior Authorization Criteria:

Tobramycin Inhalation Products include tobramycin inhalation solution, Bethkis, Kitabis Pak, Tobi, and Tobi Podhaler. New products with this classification will require the same documentation.

Coverage may be provided with a diagnosis of cystic fibrosis and the following criteria is met:

- Member is 6 years of age or older.
- Diagnosis confirmed by ONE of the following:
  - Elevated sweat chloride ≥60 mmol/L (on two occasions)
  - Presence of two disease-causing mutations in CFTR, one from each parental allele
  - Abnormal nasal potential difference measurement.
- Member has lung infection with positive culture demonstrating *Pseudomonas aeruginosa.*
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to generic tobramycin inhalation solution.
- For non-preferred agents, the member has had a trial and failure of all preferred agents or submitted a clinical reason for not having a trial of the preferred agents
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
  - Continues to benefit from treatment based on the prescriber's assessment

  Reauthorization Duration of Approval: 12 months

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TOBRAMYCIN INHALATION PRODUCTS PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:
☐ Cystic Fibrosis, ICD10: _____

- Does the member have a sweat chloride level ≥ 60 mmol/L on 2 separate occasions? ☐ Yes ☐ No
- Does genetic testing demonstrate two disease-causing mutations in CFTR, one on each parental allele? ☐ Yes ☐ No
- Does the member have abnormal nasal potential difference measurement? ☐ Yes ☐ No
- Does the member have a lung infection with a culture positive for Pseudomonas aeruginosa? ☐ Yes ☐ No

☐ Other: _____ ICD10: _____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Does the member have a lung infection with a culture positive for Pseudomonas aeruginosa? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date