

## PRIOR AUTHORIZATION REQUEST FORM EOC ID: Cayston (aztreonam oral inhalation)

#### Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.** 

Patient Name:		Prescriber Name: Supervising Physician:	
Member/Subscriber Number:		Fax:	Phone:
Date of Birth:		Office Contact:	
Group Number:		NPI:	State Lic ID:
Address:	Address:		
City, State ZIP:		City, State ZIP:	
Primary Phone:		Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for?		
Cystic Fibrosis Other		
Q2. Please provide ICD code(s) for diagnosis.		
Q3. Please indicate location of administration.		
Long Term Care (LTC) facility		
Physician office (drug from office stock - buy and bill)		
Physician office (drug from pharmacy with a prescription)		
Q4. Specify the prescriber's specialty.		
Pulmonologist		
Infectious Disease specialist		
Other (please specify)		
Q5. Is the patient 7 years old or older?		



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Patient Name:	Supervising Physician:			
🗌 Yes 🗌 No				
Q6. Does the patient have current, active Pseudomonas aeruginosa confirmed by testing?				
□ Yes □ No				
Q7. Does the patient have failure of, or contraindication to, tobramycin for oral inhalation?				
☐ Yes ☐ No				
Q8. Does the patient have an FEV1 between 25% - 75% of predicted?				
□ Yes □ No				
Q9. Does the patient have colonization with Burkholderia cepacia?				
☐ Yes ☐ No				
Q10. Additional Comments				

**Prescriber Signature** 

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.



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	Prescriber Name:
Patient Name:	Supervising Physician:

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