PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D Cayston (aztreonam inh)

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

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. Please select the diagnosis for which this drug is being prescribed.

☐ Cystic Fibrosis

☐ Other (please specify)

Q2. Please provide ICD code(s) for diagnosis.

Q3. Does patient have respiratory symptoms caused by cystic fibrosis AND a positive culture for Pseudomonas aeruginosa?

☐ Yes ☐ No

Q4. Additional comments:

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	Prescriber Name:
Patient Name:	**Supervising Physician:**

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

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