



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D - Cayston (aztreonam inh)

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.

Form with fields for Patient Name, Prescriber Name, Supervising Physician, Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, Address, City, State ZIP, Specialty/facility name, Phone, and State Lic ID.

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.
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?
Q4. Specify the prescriber's specialty.
Q5. Additional comments:



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Patient Name:	Prescriber Name: Supervising Physician:
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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 a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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