Tobramycin

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What medication is being prescribed?
   - ❑ tobramycin inhalation solution (generic)
   - ❑ Bethkis
   - ❑ TOBI
   - ❑ TOBI Podhaler
   - ❑ Kitabis Pak
   - ❑ Other _____
2. What is the diagnosis?
   - ❑ Cystic fibrosis
   - ❑ Bronchiectasis
   - ❑ Other _____
3. What is the ICD-10 code? _____
4. *If brand TOBI or TOBI Podhaler are being prescribed,* the preferred products for your patient's health plan are generic tobramycin inhalation solution and Bethkis. Can the patient's treatment be switched to one of the preferred products?
   ❑ Yes ❑ No *If Yes, specify drug, fax a new prescription to pharmacy and skip to #7:* _____
   ❑ Not applicable - brand TOBI or TOBI Podhaler are NOT being prescribed, *skip to #7.*
5. Has the patient experienced a documented intolerable adverse event to BOTH of the preferred products (i.e., generic tobramycin inhalation solution and Bethkis)? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*
6. Was the intolerable adverse event an expected adverse event attributed to the active ingredient (i.e., tobramycin) as described in the prescribing information (i.e., known adverse reaction for both the preferred and requested tobramycin inhalation product)? *If Yes, complete this form in its entirety and State Step Therapy section.*
   ❑ Yes ❑ No
7. Is the patient currently receiving therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #9*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

 Tobramycin State Step, VF, ACSF SGM - 6/2020.

8. Is the patient experiencing a benefit from therapy with the requested medication as evidenced by disease stability or disease improvement? ❑ Yes ❑ No *No further questions*

9. Is *Pseudomonas aeruginosa* present in airway cultures? *If Yes, no further questions.* ❑ Yes ❑ No

10. Does the patient have a history of *Pseudomonas aeruginosa* infection or colonization in the airways? ❑ Yes ❑ No

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (generic tobramycin inhalation solution and Bethkis) FDA-approved for the medical condition being treated? ❑ Yes ❑ No *If No, please specify:* _____

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*

7. Are any of the following conditions met for the alternate drug (generic tobramycin inhalation solution and Bethkis)?
   ❑ The alternate drug is contraindicated
   ❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
   ❑ The alternate drug is expected to be ineffective
   ❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
   ❑ The alternate drug is not in the patient's best interest
   ❑ None of the above
   If Yes, please specify: _____

8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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