Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Tobi (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-240-0536** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Tobi (FA-PA).

Drug Name (select from list of drugs shown)

Tobi (tobramycin neb sol) Tobi Podhaler (tobramycin inhal cap)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

**Diagnosis:** _____ **ICD Code:** _____

Comments: _____

**Please circle the appropriate answer for each question.**

| | | |
|---|---|---|
| 1. | The preferred products for your patient's health plan are tobramycin inhalation solution and Bethkis. Can the patient's treatment be switched to one of the preferred products? | Y N |
| 2. | Has the patient experienced a documented intolerable adverse event to at least one of the preferred products? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S). | Y N |
| 3. | 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 | Y N |

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| adverse reaction for both the preferred and requested tobramycin inhalation product)? |

I affirm that the information given on this form is true and accurate as of this date.

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| **Prescriber (Or Authorized) Signature and Date** |