Prior Authorization Form

INHALED TOBRAMYCIN (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated 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 Podhaler (tobramycin inhalation solution).

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group No:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Prescribing Physician

Physician Name:

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Address:

City, State, Zip:

Drug Name (specify drug): TOBI Podhaler (tobramycin inhalation solution)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

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Please check the appropriate answer for each applicable question.

1. The preferred products for your patient's plan are tobramycin inhalation solution and BETHKIS.
   Can the patient's treatment be switched to any of the preferred products? **Y** ☐ **N** ☐
2. Has the patient tried and experienced an intolerable adverse event to at least one of the following preferred products: tobramycin inhalation solution, BETHKIS? **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 adverse reaction for both the preferred and requested tobramycin inhalation product)? **Y** ☐ **N** ☐
4. Was this adverse event documented in the patient's chart? *Documentation is required for approval. Provide SPECIFIC and DETAILED chart documentation including description, date/time, and severity of the adverse event, dosage and duration of Preferred Product trial, required intervention (if any), and relevant tests or laboratory data (if any) OR MedWatch form of this trial and failure including the adverse reaction.* **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733.

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Prescriber (Or Authorized) Signature and Date

electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.