

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.

Drug Requested: Antibiotics-Inhaled (MEDICAID)

Preferred

<input type="checkbox"/> Tobi Podhaler®	<input type="checkbox"/> Bethkis® 300 mg/4mL	<input type="checkbox"/> Kitabis® Pak 300 mg/5mL
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Non-Preferred

<input type="checkbox"/> Cayston®	<input type="checkbox"/> Tobi® inhalation neb soln 300 mg/5mL	<input type="checkbox"/> tobramycin inhalation neb soln 300mg/5mL (generic Tobi® inhalation)
<input type="checkbox"/> tobramycin Pak (generic Kitabis® Pak)		

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Name/Form: _____ Strength: _____

Dosing Frequency: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Quantity Limits:

Bethkis® = 224 mL (56 amps)/28 days	Cayston® = 84 mL (56 amps)/28 days	Kitabis® Pak = 280 mL(56 amps)/28 days
Tobi Podhaler® = 224 capsule/28 days	Tobi® inhalation neb = 280mL (56 amps) 28 days	tobramycin = 280mL (56 amps)/28 days

MEDICAL NECESSITY: Provide clinical evidence below why the preferred drug(s) will not provide adequate benefit.

- **Bethkis®**, **Kitabis® Pak**, **Tobi®**, and **Tobi Podhaler®**: Patient is at least 6 years of age for all tobramycin inhalation nebulizer solution.
- **Cayston®**: Patient is at least 7 year of age for all tobramycin inhalation nebulizer solution.
- **Tobi Podhaler®**: clinical reason why one of the Preferred tobramycin inhalation nebulizer solutions (Bethkis® or Kitabis®) cannot be used.

****Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____