OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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**

Preferred		
❑ **Tobi Podhaler®**	❑ **Bethkis® 300 mg/4mL**	❑ **Kitabis® Pak 300 mg/5mL**

Non-Preferred		
❑ Cayston®	❑ Tobi® inhalation neb soln 300 mg/5mL	❑ tobramycin inhalation neb soln 300mg/5mL (generic Tobi® inhalation)
❑ 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.

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(Continued on next page; signature **MUST** be attached to this request.)

(Signature page MUST be attached to this request.)

****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 #: ____

REVISED/UPDATED: ~~7/6/2017;~~ ~~8/28/2017;~~ **8/15/2018**