



Send completed form to:  
 Peach State Health Plan Pharmacy Department  
 Fax: 1-866-374-1579

## Cayston

### Prior Authorization Request

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 toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Physician Office Address:** \_\_\_\_\_

1. Which drug is being prescribed?  
 Cayston Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Other \_\_\_\_\_
2. What is the diagnosis?  
 Cystic Fibrosis (CF)  
 Other \_\_\_\_\_
3. Will Cayston be administered in a **28 days on and 28 days off** cycle?  Yes  No
4. Was the diagnosis confirmed by appropriate diagnostic or genetic testing?  Yes  No
5. Is *Pseudomonas aeruginosa* present in the cultures of the airways?  Yes  No
6. Has the patient tried TOBI?  Yes  No
7. Has the patient developed intolerance or resistance to TOBI?  Yes  No
8. Will Cayston be used in conjunction with standard therapies for Cystic Fibrosis (CF)?  Yes  No
9. What is the patient's age? \_\_\_\_\_ years
10. Is the patient currently receiving Cayston? *\*If Yes, skip to # 12*  Yes  No
11. Document patient's **PRE-TREATMENT** FEV<sub>1</sub>: \_\_\_\_\_

**Only answer the below questions if patient is currently on therapy with Cayston**

12. Is the patient **less than 6** years of age?  Yes  No
13. Document patient's **CURRENT** FEV<sub>1</sub>: \_\_\_\_\_
14. Has the patient's lung function worsened while on Cayston (defined as a decrease in FEV<sub>1</sub> by greater than 10%)?  Yes  No

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Centene Cayston - MD FAX - Update 12/2010

Patient Name: \_\_\_\_\_ Patients Date of Birth: \_\_\_\_\_  
Patients ID : \_\_\_\_\_

15. Is there a clinical reason to continue Cayston therapy?  Yes  No

16. **If Yes, Document the clinical reason:**

- Patient had symptomatic improvement (e.g., decreased dyspnea, cough, fatigue; increased appetite, exercise tolerance; improved sleep)
- Patient had decreased number of pulmonary infections
- Patient had decreased number of pulmonary exacerbations
- Other \_\_\_\_\_

**\*\*NOTE: We can NOT make a decision without a copy of the documentation - Thank You\*\***

*Information given on this form is accurate as of this date:*

X \_\_\_\_\_  
Prescriber or Authorized Signature Date (mm/dd/yy)

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Centene Cayston - MD FAX - Update 12/2010