



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

TOBI

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 copay 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. What drug is being prescribed? TOBI, Dose: _____ Frequency: _____ Other _____
2. What is the diagnosis?
 Cystic Fibrosis (CF) Chronic Respiratory Infection
 Chronic Respiratory Disorder Other _____
3. Will TOBI be administered in a **28 days on and 28 days off** cycle? Yes No
4. Does the patient have known hypersensitivities to any of the aminoglycoside antibiotics (e.g., gentamicin, tobramycin, amikacin)? Yes No
5. Is *Pseudomonas aeruginosa* present in the cultures of the airways? Yes No

Complete the Section below designated for the patients diagnosis

SECTION A: Diagnosis Cystic Fibrosis (CF)

6. Was the diagnosis confirmed by appropriate diagnostic or genetic testing? Yes No
7. Will TOBI be used in conjunction with standard therapies for CF? Yes No
8. How old is the patient? _____ years
9. Is the patient currently receiving TOBI? **If Yes, skip to # 11* Yes No
10. Document patient's **PRE-TREATMENT** FEV₁: _____

Only answer questions 11-16 if patient is currently on therapy with TOBI for Cystic Fibrosis (CF)

11. Has *Pseudomonas* been eradicated after initial treatment as confirmed by repeated sputum culture?
 Yes No
12. Is the patient **less than 6** years of age? **If Yes, Skip to # 15* Yes No
13. Document patient's **CURRENT** FEV₁: _____

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

14. Has the patient's lung function worsened while on TOBI (defined as a decrease in FEV₁ by greater than 10%)? Yes No

15. Is there a clinical reason to continue TOBI 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 _____

SECTION B: Diagnosis Chronic Respiratory Infection OR Chronic Respiratory Disorder

17. Is the patient treated with recurrent courses of antibiotics? Yes No

18. Is the patient at high risk of becoming infected with resistant strains of *Pseudomonas aeruginosa*?
 Yes No

19. Document the respiratory disorder:

- Bronchiectasis
- Common variable immunodeficiency
- Immunoglobulin G (IgG) deficiency
- Selective immunoglobulin A (IgA) deficiency
- Ciliary dysfunction syndrome
- Any immunodeficient state that would result in repeated bronchial infections
- Other _____

****NOTE: We can NOT make a decision without documentation - Thank You****

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

X

Prescriber or Authorized Signature

Date (mm/dd/yy)

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