



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Cayston (aztreonam lysine) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Cayston (aztreonam lysine)**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: [1-866-331-2104](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel:1-866-331-2103). **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: <http://www.providers.kaiserpermanente.org/mas/formulary.html>**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a pulmonologist or infectious disease specialist? No Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____ Prescriber Fax #: _____

Please check the boxes that apply:

Initial Request Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #: _____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5- Diagnosis/Clinical Criteria

Initial Therapy:

1. Member has diagnosis of Cystic Fibrosis (CF) AND Pseudomonas aeruginosa is present in at least one airway culture?
 No Yes
2. Member is 7 years to 65 years?
 No Yes
3. Member has tried and failed an adequate trial of inhaled tobramycin OR inhaled tobramycin is contraindicated?
AND
 No Yes
4. Dose does not exceed 225 mg/day (75 mg three times daily) on a 28 days on/28 days off cycle?
 No Yes

Continuation of Therapy:

1. Does the member have documentation of positive clinical response to therapy based on reduction in frequency of pulmonary exacerbations and hospitalizations? **AND**
 No Yes
2. Has the member continued to be under the care of a Pulmonologist? **AND**
 No Yes

7 – Prescriber Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration:

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:

Date:

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility