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]. If you have any questions or concerns, please call 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:**

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