Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Antibiotics, Inhaled (Tobi Podhaler) Step Therapy
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year; Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Antibiotics, Inhaled (Tobi Podhaler).** 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://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Provider Information

Provider Name: ______________________________ Specialty: ________________________ NPI: __________________

Provider Address: ____

Provider Phone #: _________________________Provider 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: Name/Strength/Formulation: ____

Sig: ____

5 – Diagnosis

1. Patient Diagnosis: ____

6 – Clinical Criteria

2. Is the patient ≥ 6 years old?
   □ No □ Yes

3. Has the patient had a documented trial and failure of a preferred product (listed below)?
   □ No □ Yes; □ Bethkis □ Kitabis Pak

4. Please provide the clinical rationale as to why a preferred tobramycin inhalation nebulizer solution cannot be used.

____

____

____

____

____

7 – Provider 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.

Provider 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	