maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Arikayce

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 What is the diagnosis or indication?
[] Mycobacterium avium Complex (MAC) Lung Disease (If checked, go to 2)

[] Cystic Fibrosis (If checked, go to 14)

[] Other (If checked, no further questions)

2 Is this request for initial therapy or for a continuation of therapy?
[] Initial therapy (If checked, go to 3)

If you have any questions, call: 1-888-258-8250

Version 07.2025

PRIOR AUTHORIZATION REQUEST

[] Continuation of therapy (If checked, go to 11)

3	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
4	Has the patient completed 6 or more consecutive months of a background multidrug regimen? [NOTE: A multidrug regimen typically includes a macrolide (azithromycin or clarithromycin), ethambutol, and a rifamycin (rifampin or rifabutin).] [If no, no further questions.]	Yes	No
5	Does the patient have a positive sputum culture for Mycobacterium avium complex? [If no, no further questions.]	Yes	No
6	Was the sputum culture collected within the past 3 months? [If no, no further questions.]	Yes	No
7	Was the sputum culture collected AFTER the patient has completed 6 or more consecutive months of a background multidrug regimen? [If no, no further questions.]	Yes	No
8	Is the Mycobacterium avium complex isolate susceptible to amikacin with a minimum inhibitor concentration (MIC) of LESS THAN or EQUAL TO 64 micrograms/mL? [If no, no further questions.]	Yes	No
9	Will the requested medication be used in combination with a background multidrug regimen? [NOTE: A multidrug regimen typically includes a macrolide (azithromycin or clarithromycin), ethambutol, and a rifamycin (rifampin or rifabutin).] [If no, no further questions.]	Yes	No
10	Is the requested medication being prescribed by a pulmonologist, infectious diseases physician, or a physician who specializes in the treatment of Mycobacterium avium complex lung infections? [No further questions.]	Yes	No
11	Will the requested medication be used in combination with a background multidrug regimen? [NOTE: A multidrug regimen typically includes a macrolide (azithromycin or clarithromycin), ethambutol, and a rifamycin (rifampin or rifabutin).] [If no, no further questions.]	Yes	No
12	Has the patient achieved negative sputum cultures for Mycobacterium avium complex? [If no, no further questions.]	Yes	No

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13	Has the patient achieved negative sputum cultures for Mycobacterium avium complex for LESS THAN 12 months? [REVIEWER NOTE: Approve enough Arikayce to complete 12 months of therapy following a negative sputum culture for Mycobacterium avium complex.] [No further questions.]	Yes	No
14	Does the patient have Pseudomonas aeruginosa in culture of the airway (for example, sputum culture, oropharyngeal culture, bronchoalveolar lavage culture)? [If no, no further questions.]	Yes	No
15	Is the requested medication being prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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