maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Cayston

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.

CRITERIA FOR APPROVAL

1 What is the diagnosis or indication?
[] Cystic fibrosis (If checked, go to 2)

[] Other (If checked, no further questions)

2 Is the patient 7 years of age or older? Yes No
[If no, no further questions.]

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

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3	Does the patient have a forced expiratory volume in one second (FEV1) between 25-75% predicted? [If no, no further questions.]	Yes	No
4	Are the patient's sputum cultures positive for Pseudomonas aeruginosa? [If no, no further questions.]	Yes	No
5	Is the patient's sputum colonized with Burkholderia cepacia? [If yes, no further questions.]	Yes	No
6	Does the patient have contraindication or intolerance to tobramycin?	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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