PRIOR AUTHORIZATION REQUEST

ANTIBIOTICS (INHALED) - 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	Is this request for INITIAL or CONTINUATION of therapy with the requested medication? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No

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

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 8.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
5	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
6	Has the patient achieved negative sputum cultures for Mycobacterium avium complex for less than 12 months? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	What is the diagnosis or indication? [] Mycobacterium avium Complex (MAC) Lung Disease (If checked, go to 9) [] Cystic Fibrosis (If checked, go to 18) [] Other (If checked, no further questions)		
9	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
10	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
11	Does the patient have a positive sputum culture for Mycobacterium avium complex? [If no, no further questions.]	Yes	No

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12	Was the sputum culture collected within the past 3 months? [If no, no further questions.]	Yes	No
13	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
14	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
15	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
16	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? [If no, no further questions.]	Yes	No
17	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? [No further questions.] [NOTE: Dosing is one vial (590 mg) via nebulizer once daily.]	Yes	No
18	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
19	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
20	Is the requested medication being prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis? [If no, no further questions.]	Yes	No
21	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for the indication? [NOTE: Dosing is one vial (590 mg) via nebulizer once daily.]	Yes	No

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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.

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