pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANTIBIOTICS, INHALED PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**
- To review the prior authorization guidelines for Inhaled Antibiotics, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Antibiotics, Inhaled** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to **Quantity Limits / Daily Dose Limits** at: http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Additional info ☐Renewal request (PA# _____)	# of pages in request: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/State/Zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested (*Names in parentheses are the brand name equivalents included for reference purposes.*)
☐Cayston vial ☐TOBI Podhaler capsule ☐tobramycin pak 300mg/5 ml ampule *(Kitabis Pak)*
☐TOBI vial ☐tobramycin 300 mg/5 ml ampule *(TOBI vial)*

Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

1. Has the Recipient tried and failed any of the preferred Inhaled Antibiotics? *Check all that apply.* ☐Bethkis ☐Kitabis Pak	☐Yes – *submit all supporting documentation of drug regimen and therapeutic failure* ☐No
2. Does the Recipient have any contraindications or intolerances to the preferred agents listed in question (1)?	☐Yes – *submit all supporting documentation of medication name(s) and associated intolerances and contraindications* ☐No
3. Has a culture and sensitivity (C&S) test been performed, and do the results indicate that only a non-preferred Inhaled Antibiotic will be effective?	☐Yes – *submit results of culture and sensitivity tests* ☐No – *submit documentation supporting the medical necessity of the requested non-preferred agent*
4. *For requests for Cayston*, does the Recipient have a diagnosis of cystic fibrosis (CF) WITH Pseudomonas aeruginosa present in the lungs?	☐Yes – *submit results of lab testing* ☐No – *submit documentation supporting the medical necessity of Cayston*
5. Inhaled Antibiotics are part of the Department's Specialty Pharmacy Drug Program (SPDP). What Specialty Pharmacy will be used? (Refer to the Department's SPDP website for more information: http://www.dhs.pa.gov/provider/pharmacyservices/thespecialtypharmacydrugprogram/index.htm.)	☐Diplomat Specialty Pharmacy ☐Walgreens Specialty Pharmacy

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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