

TOBI® & TOBI® Podhaler Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		Office Contact:
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>		
Medication Name: Select one of the following: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic)		Strength:
<input type="checkbox"/> Check if request is for continuation of therapy		Dosage Form:
Directions for Use:		

Clinical Information <small>(required)</small>
Select the Type(s) of Coverage Determination Requested: <input type="checkbox"/> Non-Formulary - Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year. <input type="checkbox"/> Prior Authorization - Request is for a drug that requires prior authorization under the plan.
Select the diagnosis below: <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
Medication History: For TOBI, select if the patient has had a history of trial and failure, or intolerance to the following: <input type="checkbox"/> Bethkis <input type="checkbox"/> TOBI Podhaler <input type="checkbox"/> Tobramycin inhalation solution <input type="checkbox"/> Other drugs in the same class. Please specify: _____ <input type="checkbox"/> Other therapeutic equivalent alternatives. Please specify: _____
Clinical Information: Is there documentation that the patient has evidence of Pseudomonas aeruginosa in the lungs? <input type="checkbox"/> Yes <input type="checkbox"/> No
B versus D Benefit: Is the requested medication being used with a nebulizer? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested medication being given in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested medication used with a metered dose inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested medication being used via a non-nebulized route? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested medication being used in a long term care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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