Prescriber Criteria Form

Tobramycin BDC 2026 PA Fax 232-A v1 010126.docx
Inhalation Solutions - Tobramycin
Bethkis, Kitabis Pak, Tobi (tobramycin inhalation solution)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Inhalation Solutions - Tobramycin.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.

B vs D CRITERIA FOR DETERMINATION			
1	Is the patient using the requested drug with a nebulizer? [If no, then skip to question 3.]	Yes	No
2	Does the patient have a diagnosis of cystic fibrosis or bronchiectasis (ICD-10 diagnosis codes A15.0, E84.0, J47.0, J47.1, J47.9, Q33.4)? [If yes, then no further questions.]	Yes	No
CRITERIA FOR APPROVAL			
3	Does the patient have a diagnosis of cystic fibrosis? [If yes, then skip to question 5.]	Yes	No
4	Does the patient have a diagnosis of non-cystic fibrosis bronchiectasis? [If no, then no further questions.]	Yes	No
5	Does the patient meet one of the following criteria: A) Pseudomonas aeruginosa is present in the patient's airway cultures, B) patient has a history of Pseudomonas aeruginosa infection or colonization in the airways?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____