Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Bethkis (tobramycin), **Cayston** (aztreonam lysine), **Kitabis Pak** (tobramycin), **TOBI** (tobramycin), **TOBI Podhaler** (tobramycin)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: ICD10:
☐ Bethkis 300mg/4ml solution for inhalation
☐ Cayston inhalation solution 75mg/ml vial
☐ Kitabis Pak 300mg/5ml solution for inhalation
☐ TOBI 300mg/5ml solution for inhalation
☐ TOBI Podhaler 28mg powder for inhalation
☐ tobramycin ampule for nebulization (generic Bethkis)
☐ tobramycin 300mg/5mL solution for inhalation (generic TOBI)
☐ tobramycin inhalation solution pak 300mg/5mL (generic Kitabis Pak)

Strength & Dose: Quantity prescribed per month: Frequency of administration:

Does your patient require continual treatment for more than 28 days at a time without a 28 day break in therapy? ☐ Yes ☐ No
(if yes) Please explain why your patient is unable to follow the standard therapy regimen (28 days on, 28 days off before resuming).

Where will this medication be obtained?
☐ Cigna Home Delivery *(Cigna's nationally preferred specialty pharmacy)*
☐ Physician's office stock
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):_____
☐ Ambulatory Infusion Center
☐ Hospital - In patient
☐ Hospital - Out patient
☐ Other *(please specify)*:

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ cystic fibrosis (CF)
☐ non-cystic fibrosis bronchiectasis
☐ other *(please specify)*:

Clinical Information:
Does your patient have documentation of *Pseudomonas aeruginosa* in airway cultures? ☐ Yes ☐ No

if Bethkis, Cayston, Kitabis Pak, TOBI, TOBI Podhaler, generic TOBI, tobramycin generic Kitabis Pak:
(if non-cystic fibrosis bronchiectasis) Has your patient had 3 or more exacerbations per year? ☐ Yes ☐ No
(if non-cystic fibrosis bronchiectasis) Has your patient tried and failed long-term oral antibiotics (for example, macrolides for 6 months)? ☐ Yes ☐ No
(if no) Is your patient able to try long-term oral antibiotics? ☐ Yes ☐ No
(if no) Please list all reasons that your patient is not a candidate for long-term oral antibiotics.

if generic Bethkis:
(if CF) Is this drug being prescribed by, or in consultation with, a pulmonologist or a physician who specializes in the treatment of cystic fibrosis? ☐ Yes ☐ No
(if non-CF bronchiectasis) Is this drug being prescribed by, or in consultation with, a pulmonologist? ☐ Yes ☐ No

Did your patient try Kitabis Pak (tobramycin 300 mg/5 mL nebulization solution), but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No
(if no) Is your patient able to try the alternative, Kitabis Pak (tobramycin 300 mg/5 mL nebulization solution)? ☐ Yes ☐ No
(if no) What is the reason your patient can not try the alternative, Kitabis Pak (tobramycin 300 mg/5 mL nebulization solution)?
☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is unable to take the alternative and requires the dosage formulation of the requested drug.
☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other
Please provide specifics to support this reason. _____

Did your patient try TOBI Podhaler, but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No
(if no) Is your patient able to try the alternative, TOBI Podhaler? ☐ Yes ☐ No
(if no) What is the reason your patient can not try the alternative, TOBI Podhaler?
☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is unable to take the alternative and requires the dosage formulation of the requested drug.
☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other
Please provide specifics to support this reason. _____

Did your patient try tobramycin 300 mg/5 mL nebulization solution, but it either did not work well enough OR caused a significant intolerance? ☐ Yes ☐ No
(if no) Is your patient able to try the alternative, tobramycin 300 mg/5 mL nebulization solution? ☐ Yes ☐ No
(if no) What is the reason your patient can not try the alternative, tobramycin 300 mg/5 mL nebulization solution?
☐ Patient has at least one contraindication or warning as listed in the alternative drug's prescribing information.
☐ Patient is unable to take the alternative and requires the dosage formulation of the requested drug.
☐ Patient is not a candidate for the alternative due to a disease characteristic, individual clinical factor[s], or other attribute/condition.
☐ other
Please provide specifics to support this reason. _____

Additional Pertinent Information: *Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives considered standard therapy, etc). Please provide drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced:*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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