SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Antibiotics-Inhaled

Drug Requested: (Check below all that apply)

PREFERRED	
❑ **Bethkis® 300 mg/4mL (QL, AG)**	❑ **Kitabis® Pak 300 mg/5mL (QL, AG)**
❑ **Tobi Podhaler® (QL, AG, SE)**	❑ **tobramycin inhalation neb soln** 300mg/5mL (generic Tobi® inhalation) **(QL, AG)**
Non-Preferred	
❑ **Arikayce® (QL, PA required) (Refer to Arikayce PA form)**	❑ **Cayston® (QL, AG)**
❑ **Tobi® inhalation neb soln** 300mg/5mL **(QL, AG)**	❑ **tobramycin inhalation** (generic Bethkis®) **(QL, AG)**
❑ **tobramycin Pak** (generic Kitabis® Pak) **(QL, AG)**	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

(Continued on next page)

Quantity Limits		
Arikayce = 590 mg/8.4 mL (28 vials)/ 28 days	Bethkis® = 224 mL (56 amps)/ 28 days	Cayston® = 84 mL (56 amps)/ 28 days
Kitabis® Pak = 280 mL(56 amps)/ 28 days	Tobi Podhaler® = 224 capsule/ 28 days	Tobi® inhalation neb = 280mL (56 amps)/ 28 days
tobramycin = 280mL (56 amps)/ 28 days		

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Minimum age for use is 6 years for all tobramycin inhalation nebulizer solution (Bethkis®, Kitabis™ Pak, Tobi® and Tobi Podhaler®) and 7 years for Cayston®.

- **Tobi Podhaler®**: clinical reason why ONE (1) of the **PREFERRED** tobramycin inhalation nebulizer solutions cannot be used.

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Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

REVISED/REFORMATTED/UPDATED: ~~7/6/2017; 8/28/2017; 8/15/2018; 6/10/2019; 12/24/2019; 6/29/2021;12/27/2022; 11/8/2023;~~ **1/20/2026**;