P.O. Box 30192
Salt Lake City, UT 84120-0192
801-442-4912 or 800-442-3219
Fax 801-442-3006

selecthealth

PREAUTHORIZATION FORM

Tobi®, Cayston®

(Inhaled Tobramycin, Inhaled Aztreonam)

Therapeutic use: Treatment of cystic fibrosis
Quantity Limit: six 28-day cycles within 12 months
Authorization Period: 12 months

Patient's name ____________________

Patient's ID# [ ] DOB [ ]/[ ]/[ ]

ICD-9 [ ] ____________________

Physician's name ____________________

Physician's Ph# ( ) - Fax# -

Physician's signature ____________________ Date signed / /

Supervising Physician's name ____________________ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Which medication is being requested? ❑ Tobi ❑ Cayston		
2.	Is the prescribing physician a pulmonologist?	❑ Yes	❑ No
3.	Does the patient have a diagnosis of cystic fibrosis? If no, then list diagnosis: ____________________	❑ Yes	❑ No
4.	Has the patient had a positive culture for *Pseudomonas aeruginosa* at any time in the past?	❑ Yes	❑ No

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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