

# ARIKAYCE

## PRIOR AUTHORIZATION REQUEST

### PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermyeds.com](http://covermyeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

**Today’s Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today’s Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip		Patient Telephone:
Member ID Number:		Group Number:	

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Please select the patient’s diagnosis:

- Mycobacterium avium* complex (MAC) lung disease
- Other (ICD code, plus description): \_\_\_\_\_

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

**For all requests:**

- Is the patient currently being treated with the requested agent? .....  Yes  No
- Does the patient have any FDA labeled contraindications to the requested agent? .....  Yes  No  
If yes, please specify contraindications: \_\_\_\_\_
- Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., infectious disease, immunologist, pulmonologist, thoracic specialist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? .....  Yes  No
- Is the patient’s age within FDA labeling for the requested indication for the requested agent? .....  Yes  No  
If no, please provide support for using the requested agent for the patient’s age for the requested indication: \_\_\_\_\_
- Will the patient continue treatment with guideline-based based combination antibiotic therapy for *Mycobacterium avium* complex (MAC) lung disease with the requested agent (e.g., combination may include a macrolide [clarithromycin, azithromycin], a rifamycin [rifampin, rifabutin], and ethambutol)? .....  Yes  No
- Is the patient currently being treated with another inhaled antibiotic (e.g., aztreonam for inhalation, tobramycin for inhalation)? .....  Yes  No  
If yes, will the patient discontinue the other inhaled antibiotic prior to starting the requested agent? .....  Yes  No  
If no, please provide support for the use of another inhaled antibiotic concurrently with the requested agent: \_\_\_\_\_
- Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>8. Does the patient have positive sputum cultures despite at least 6 consecutive months of treatment with guideline-based combination antibiotic therapy for MAC lung disease (e.g., standard combination may include a macrolide [clarithromycin, azithromycin], a rifamycin [rifampin, rifabutin], and ethambutol)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>For <i>Mycobacterium avium</i> complex (MAC) lung disease requests:</b>  <b>Please submit medical records for the following questions:</b></p> <p>9. Has the patient's diagnosis of MAC been confirmed by pulmonary or systemic symptoms?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Has the patient's diagnosis of MAC been confirmed by nodular or cavitary opacities on chest radiograph? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  If no, has the patient's diagnosis of MAC been confirmed a high-resolution computed tomography scan that shows multifocal bronchiectasis with multiple small nodules? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Has the patient's diagnosis of MAC been confirmed by positive culture results from at least TWO separate expectorated sputum samples? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  If no, has the patient's diagnosis of MAC been confirmed by a positive culture result from at least ONE bronchial wash or lavage? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  If no, has the patient's diagnosis of MAC been confirmed by transbronchial or other lung biopsy with mycobacterial histopathologic features (granulomatous inflammation or acid-fast bacilli [AFB])? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, has the patient's diagnosis of MAC been confirmed by transbronchial or other lung biopsy specimen that are culture positive for NTM? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  If no, has the patient's diagnosis of MAC been confirmed by one or more sputum or bronchial washings that are culture positive for NTM? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Has the patient's diagnosis of MAC been confirmed by appropriate exclusion of other diagnoses? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p><b>For renewal requests:</b></p> <p>13. Has the patient had clinical benefit with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p><b>Please fax or mail this form to:</b>  Prime Therapeutics LLC  Clinical Review Department  2900 Ames Crossing Road Suite 200  Eagan, MN 55121</p> <p><b>TOLL FREE</b></p>		<p><b>CONFIDENTIALITY NOTICE:</b> This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.</p>	
<p><b>Phone:</b>  <b>BCBSIL: 800.285.9426</b>  <b>BCBSMT: 888.723.7443</b>  <b>BCBSNM: 800.544.1378</b>  <b>BCBSOK: 800.991.5643</b>  <b>BCBSTX: 800.289.1525</b></p>	<p><b>Fax: 877.243.6930</b></p>		