Prescriber Criteria Form

Arikayce 2025 PA Fax 2848-A v1 010125.docx
Arikayce (amikacin liposome inhalation suspension)
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 Arikayce (amikacin liposome inhalation suspension).

Drug Name:
Arikayce (amikacin liposome inhalation suspension)

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.			
1	Does the patient have a diagnosis of refractory mycobacterium avium complex (MAC) lung disease? [If no, then no further questions.]	Yes ◯	No ◯
2	Does the patient have positive sputum cultures after being treated with a multidrug background regimen therapy for a minimum of 6 consecutive months? [If no, then no further questions.]	Yes ◯	No ◯
3	Will the requested medication be used as part of a combination antibacterial drug regimen?	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:**_____