Prescriber Criteria Form

Cayston 2025 PA Fax 480-A v1 010125.docx
Cayston (aztreonam inhalation solution)
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 Cayston (aztreonam inhalation solution).

Drug Name:
Cayston (aztreonam inhalation solution)

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	Is the drug being requested for the treatment of respiratory symptoms in a patient with a diagnosis of cystic fibrosis? [If no, then no further questions.]	Yes ◯	No ◯
2	Does the patient meet either of the following criteria: A) Pseudomonas aeruginosa is present in the cultures of the airways, B) the patient has a history of Pseudomonas aeruginosa infection or colonization in the airways?	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:**_____