Prescriber Criteria Form

Tobi Podhaler 2025 PA Fax 1507-A v1 010125.docx
Tobi Podhaler (tobramycin inhalation powder)
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 Tobi Podhaler (tobramycin inhalation powder).

Drug Name:
Tobi Podhaler (tobramycin inhalation powder)

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 cystic fibrosis? [If yes, then skip to question 3.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of non-cystic fibrosis bronchiectasis? [If no, then no further questions.]	Yes ◯	No ◯
3	Does the patient meet one of the following criteria: A) Pseudomonas aeruginosa is present in the patient's airway cultures, 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:**_____