TRICARE Prior Authorization Request Form for
amikacin sulfate liposomal inhalation suspension (**Arikayce**)

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by or in consultation with an Infectious Disease Specialist and/or Pulmonologist?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Does the patient have a diagnosis of refractory Mycobacterium avium complex (MAC) lung disease?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4. Has the patient achieved negative sputum cultures after a minimum of 6 consecutive months of conventional therapy?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question 5
5. Does the patient's infection continue to be susceptible to amikacin?	☐ Yes Proceed to question 6	☐ No **STOP** **Coverage not approved**
6. Is the patient on a concomitant multidrug background (baseline) regimen therapy?	☐ Yes Proceed to question 7	☐ No **STOP** **Coverage not approved**

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7. Does the provider acknowledge and has the patient been informed that Arikayce, carries a boxed warning for risk of increased respiratory adverse reactions that can lead to hospitalization?	☐ Yes Proceed to question 8	☐ No **STOP** **Coverage not approved**
8. Does the provider acknowledge and has the patient been informed that warnings and precautions of Arikayce include: hypersensitivity pneumonitis, hemoptysis, bronchospasm, exacerbation of underlying pulmonary disease, ototoxicity, nephrotoxicity, neuromuscular blockade, and embryo-fetal toxicity?	☐ Yes Proceed to question 9	☐ No **STOP** **Coverage not approved**
9. Does the provider acknowledge and has the patient been informed, that the patient will be monitored for adverse reactions that include but are not limited to: (from package insert occurring at an incidence of greater than or equal to 10% and higher than control) dysphonia, cough, bronchospasm, hemoptysis, ototoxicity, upper airway irritation, musculoskeletal pain, fatigue/asthenia, exacerbation of underlying pulmonary disease, diarrhea, and nausea?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[15 Nov 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: