

**Physician's Prior Authorization Questionnaire
Tobi®**

Patient:

ID#:

DOB:

Patient Address:

Tobi® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(No codes please.)* _____

2. Does the patient have cystic fibrosis? Yes No

If yes, stop here. There is no need to answer remaining questions.

3. Does the patient have a positive sputum culture for Pseudomonas aeruginosa? Yes No

4. Is the patient immunocompromised? Yes No

If yes, please explain: _____

Tobi® will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx