Cayston Access Program®

for Cayston (aztreonam for inhalation solution)

1-877-7CAYSTON (1-877-722-9786) Fax: 1-877-550-1705

Statement of Medical Necessity

1. Service(s) Requested

☐ Insurance Verification & Specialty Pharmacy Referral ☐ Co-Pay Assistance Referral

☐ Cayston Patient Assistance Program Referral (assistance for uninsured patients)

2. Patient Information

Name: _____ Birth Date: ___/___/___ Gender: ☐ M ☐ F

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Contact: _____ Relationship: _____

Home Ph: (___) _____ Work Ph: (___) _____ Cell Ph: (___) _____

E-mail : _____

Preferred Ph: ☐ Home ☐ Work ☐ Cell ☐ OK to Leave Message

3. Insurance Information for Medical and Pharmacy Benefits (Attach copy, front and back, of patient insurance card[s])

☐ Check here if you are attaching a copy of the patient's insurance card(s). If you are attaching copies you do not need to complete the insurance information below.

Primary Insurance: _____ Phone : (___) _____

Card Holder Name: _____ Birth Date: ___/___/___

ID #: _____ Group #: _____

Check all that apply: ☐ Medical insurance benefits ☐ Pharmacy benefits

Secondary Insurance: _____ Phone : (___) _____

Card Holder Name: _____ Birth Date: ___/___/___

ID #: _____ Group #: _____

Check all that apply: ☐ Medical insurance benefits ☐ Pharmacy benefits

4. Diagnosis and Clinical Information (This is for insurance purposes only, not to suggest approved uses or indications)

Diagnosis (Indicate 1 for primary diagnosis, 2 for secondary diagnosis):

☐ Cystic Fibrosis (277.0) ☐ Cystic Fibrosis with Pulmonary Manifestations (277.02)

☐ *Pseudomonas aeruginosa* (041.7) ☐ Other, Please Specify ICD-9 Diagnosis Code:

Inhaled Antibiotics Treatment History:

☐ TOBI® (tobramycin inhalation solution, USP) ☐ Other, Please Specify:

FEV_1 Percent Predicted: ☐ < 25% ☐ ≥ 25% - ≤ 75% ☐ > 75%

Notes: _____

Cayston Access Program, 6931 Arlington Road, Suite 308, Bethesda, MD 20814
Monday-Friday 8 AM–8 PM EST

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Statement of Medical Necessity (cont'd)

5. Prescription

Cayston: Frequency: ☐ Three Times a Day Dispense: ☐ 28-day Supply

Refills: _____

Special Instructions: _____

Altera® Nebulizer Handset: Dispense: ☐ 1 Handset

Note: If prescribed, 1 additional Altera Handset will be provided per 28-day supply of Cayston.

Altera Nebulizer System: Dispense: ☐ 1 Altera Nebulizer System (Includes Controller, 1 Altera Handset, Nebulizer Connection Cord, AC Power Supply, 4 AA Batteries)

Drug Allergies: _____

☐ Dispense as written

6. Pharmacy Preference

☐ Foundation Care ☐ IV Solutions/Maxor ☐ Pharmaceutical Specialties, Inc.

☐ TLCRx/ModernHEALTH ☐ Walgreens Specialty

7. Prescriber and Patient Advocate Information

Prescriber Name: _____ Title: _____ Office/Clinic/Institution: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Work Ph: (____) _____ Ext: _____ Alternate Ph: (____) _____ Fax: (____) _____

E-mail: _____

DEA #: _____ NPI #: _____

Patient Advocate Name: _____ Office/Clinic/Institution: _____

Title: Nurse/Social Worker/Case Manager/Other (circle one)

Address: _____

City: _____ State: _____ Zip Code: _____

Work Ph: (____) _____ Ext: _____ Alternate Ph: (____) _____ Fax: (____) _____

E-mail: _____

A Patient Advocate may be a healthcare worker involved in the patient's care—a nurse, social worker, or case manager. Friends or family members cannot act as Patient Advocates.

By signing below, I certify that (1) the above therapy is medically necessary; (2) I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to release the above information to Gilead and contractors designated by Gilead for the purposes of verifying the patient's insurance coverage for Cayston and the Altera Nebulizer System, seeking prior authorization for Cayston and the Altera Nebulizer System, if needed, on my patient's behalf, providing information on appeals of denials of claims, coordinating delivery of Cayston and the Altera Nebulizer System to my patient's preferred site, and providing me and my patient with other educational and support services associated with Cayston therapy and the Altera Nebulizer System; (3) I will not sell or bill any free product received in my office; and (4) I authorize the above prescription to be forwarded to the pharmacy chosen by the named patient.

Prescriber Signature (No stamps): _____ **Date:** _____

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Instructions for Completing the Statement of Medical Necessity

1. Service(s) Requested

- Select the services that you are requesting to ensure the Cayston Access Program reimbursement specialists can best meet your needs.
- If you require support to determine which service request type is most appropriate for your needs, you may call 1-877-7CAYSTON (1-877-722-9786) for assistance.

2. Patient Information

- Please include the primary contact, if other than the patient, their relationship to the patient, and their preferred phone number.

3. Insurance Information for Medical and Pharmacy Benefits (Attach copy, front and back, of patient insurance card[s])

- Fill out this section for all forms of the patient's insurance coverage or fax copies (front and back) of the patient's insurance card(s) (may be 1 or more cards for both the patient's medical and pharmacy benefits) to 1-877-550-1705.

4. Diagnosis and Clinical Information

- Select the appropriate diagnosis code. If other is selected, please specify the ICD-9 diagnosis code.
- Specify current or previous inhaled antibiotic therapy.
- Check the appropriate FEV_1 % predicted severity category.
- Include in the notes section any additional medical justification for treatment with Cayston.

5. Prescription

- Complete all areas of the prescription section of the form completely.
- If prescribed, 1 additional Altera® Nebulizer Handset will be provided per 28-day supply of Cayston.

6. Pharmacy Preference

- Select the dispensing specialty pharmacy for Cayston, the Altera Nebulizer Handset, and the Altera Nebulizer System.
- The patient will be notified prior to shipment by the dispensing specialty pharmacy.

7. Prescriber and Patient Advocate Information

- Provide the DEA number or a copy of state license for the prescribing healthcare professional.
- Please specify a Patient Advocate that may serve as an alternate point of contact for the prescribing healthcare professional. A Patient Advocate may be a healthcare worker involved in the patient's care—a nurse, social worker, or case manager. Friends or family members cannot act as Patient Advocates.
- Ensure the prescribing healthcare professional signs and dates the Statement of Medical Necessity Form.

All of the following items must be completed and submitted to the Cayston Access Program in order for your request to be processed

- ☐ Did you submit a completed Statement of Medical Necessity Form, including the prescribing healthcare professional's signature?
- ☐ Did you submit a copy (front and back) of all insurance cards?
- ☐ Did you submit a completed Patient Authorization Form, including the patient or legal guardian's signature on the form?

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