Montana Healthcare Programs
Drug Prior Authorization Coverage Criteria

Cayston™ (aztreonam)

Review Criteria

Member must meet all the following criteria:

- Subject to Preferred Drug List requirements

- Diagnosis of Cystic Fibrosis
    - Approve for 1 year with annual updates

- Diagnosis other than cystic fibrosis
    - Specialist consult required (pulmonologist or infectious disease).
        - Documented chronic diagnosis
        - PA x 3 months then update if needed