Montana Healthcare Programs
Drug Prior Authorization Coverage Criteria

# Tobi Podhaler™ (tobramycin)

## Review Criteria

Member must meet all the following criteria:

- Subject to Preferred Drug List requirements
  - Member must have a therapeutic failure on at least one other preferred product first

- Diagnosis of cystic fibrosis
  - Approve for one year with annual updates

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