



Montana Healthcare Programs  
Drug Prior Authorization Coverage Criteria

Tobi™ (tobramycin)

**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 consultation required (pulmonologist or infectious disease)
    - Documented chronic diagnosis
    - Prior authorization x 3 months then update if needed