

Clinical Pharmacy Program Guidelines for Cayston

Program	Prior Authorization
Medication	Cayston [®] (aztreonam for inhalation solution)
Markets in Scope	Arizona, California, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania- CHIP, Rhode Island, South Carolina
Issue Date	6/2013
Pharmacy and Therapeutics Approval Date	2/2020
Effective Date	4/2020

1. Background:

Cayston (aztreonam solution for inhalation) is a monobactam antibacterial indicated to improve respiratory symptoms in cystic fibrosis (CF) patients with *Pseudomonas aeruginosa*. Safety and effectiveness have not been established in pediatric patients below the age of 7 years, patients with forced expiratory volume (FEV₁) < 25% or > 75% predicted, or patients colonized with *Burkholderia cepacia*.¹

To reduce the development of drug-resistant bacteria and maintain the effectiveness of Cayston and other antibacterial drugs, Cayston should be used only to treat patients with CF known to have *Pseudomonas aeruginosa* in the lungs.

2. Coverage Criteria:

<p>A. <u>Authorization</u></p> <p>1. Cayston will be approved based on the following criteria:</p> <p style="padding-left: 20px;">a. Diagnosis of cystic fibrosis (CF)</p> <p style="padding-left: 20px;">Authorization will be issued for 12 months.</p>
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3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

- Supply limits may be in place.

4. References:

1. Cayston [package insert]. Foster City, CA: Gilead Sciences, Inc.; November 2019.

Program	Prior Authorization –Cayston (aztreonam for inhalation solution)
Change Control	
Date	Change
6/2013	New drug policy
3/2014	<ul style="list-style-type: none"> • Updated length of authorization to 60 months. • Removed initial authorization designation and removed reauthorization criteria. • In the Reference Section, the reference for acute exacerbation of cystic fibrosis guideline has been removed • In the Reference Section, updated cystic fibrosis guideline reference for chronic maintenance therapy which was updated in April 2013
12/2015	Annual Review, no change
10/2016	Added reauthorization criteria to align with Employer & Individual’s policy. Updated policy template.
2/2017	Updated policy template
9/2017	Removed lung infection with positive culture requirement and reauthorization criteria to allow for Dx to Rx implementation
2/2018	Annual review. No changes to criteria.
2/2019	Annual review. No changes to criteria.
2/2020	Annual review. Updated reference.