

Effective Date: 7/2018
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Scope: Medicaid

## **Tobramycin Inhalation Solution**

### **POLICY**

#### **INITIAL CRITERIA**

The requested drug will be covered for 12 months with prior authorization when the following criteria are met:

- Patient is 6 years of age or older  
**AND**
- The requested drug is being prescribed for the management of cystic fibrosis in patients with *Pseudomonas aeruginosa*  
**OR**
- The requested drug is being prescribed for the treatment of non-cystic fibrosis bronchiectasis and chronic bronchial infection with *Pseudomonas aeruginosa*

#### **CONTINUATION OF THERAPY**

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Initial Criteria who are experiencing benefit from therapy as evidenced by disease stability or disease improvement.

#### **QUANTITY LIMIT**

- 280 ml per 28 days

#### **REFERENCES**

1. Tobramycin inhalation solution [package insert]. Parsippany, NJ: Teva Pharmaceuticals USA; February 2023.