

UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

Program Number	2026 P 3153-6
Program	Step Therapy
Medication	Cayston® (aztreonam for inhalation solution)
P&T Approval Date	2/2021, 2/2021, 2/2022, 2/2023, 2/2024, 2/2025, 2/2026
Effective Date	5/1/2026

**1. Background:**

Step therapy programs are utilized to encourage use of lower cost alternatives for certain therapeutic classes. This program requires a member to try preferred products before providing coverage for Cayston.

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

Tobramycin inhalation solution is an aminoglycoside antibacterial indicated for the management of cystic fibrosis patients with *P. aeruginosa*. Safety and effectiveness have not been established in patients under the age of 6 years, patients with FEV<sub>1</sub> < 25% or > 75% predicted, or patients colonized with *B. capecia*.<sup>2</sup>

Members currently on Cayston as documented in claims history will be allowed continued coverage of their current therapy. Members new to therapy will be required to meet the coverage criteria below.

**2. Coverage Criteria<sup>a</sup>:**

<p><b>A. Cayston</b> will be approved based on the following criterion:</p> <ol style="list-style-type: none"> <li>History of failure, contraindication, or intolerance to tobramycin inhalation solution (document date of trial and list reason for therapeutic failure, contraindication, or intolerance)</li> </ol> <p style="text-align: center;"><b>Authorization will be issued for 12 months.</b></p> <p><sup>a</sup> State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.</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.
- Medical Necessity, Supply Limits and/or Notification may be in place.

- Not all tobramycin products are covered. Refer to the most current UHC prescription drug list to identify covered products.

**4. References:**

1. Cayston [package insert]. Foster City, CA: Gilead Sciences, Inc.; November 2019.
2. Tobramycin [package insert]. Princeton, NJ: Dr. Reddy's Laboratories, Inc.. February 2023.
3. Mogayzel PJ Jr, Naureckas ET, Robinson KA, et al. Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. Am J Respir Crit Care Med. 2013;187(7):680-689. doi:10.1164/rccm.201207-1160oe

Program	Step Therapy – Cayston (aztreonam for inhalation solution)
<b>Change Control</b>	
2/2021	New program.
2/2022	Annual review with no changes to coverage criteria. Updated background and references.
2/2023	Annual review with no changes to coverage criteria. Updated references.
2/2024	Annual review with no changes to coverage criteria. Updated background and references.
2/2025	Annual review. No changes to coverage criteria. Updated reference.
2/2026	Annual review. No changes to coverage criteria. Updated reference.