Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Off Label Products (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Off Label Products (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name

Specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis:_____ ICD Code:_____

Circle the appropriate answer for each question.

1. Is the request for continuation of therapy? Y N

   [If yes, skip to question 5]

2. Did the patient have a trial and failure or intolerance to all FDA–approved medications for the indication? Y N

   (Please provide documentation)

3. Do Phase III clinical studies published in peer review journals support the non-FDA approved use? Y N

   [If no, then no further questions]

4. Is usage supported by publications in peer reviewed medical Y N

literature in one or more citations in at least one of the following compendia:

-American Hospital Formulary Service Drug Information (AHFS)

-United States Pharmacopeia-Drug Information (or its successor publications)

-DRUGDEX Information System

[No further questions.]

5. Has the patient shown a clinical response to treatment? Y N

   (Please provide documentation of clinical response, as measured by applicable laboratory tests, radiologic studies or other markers of disease response to therapy)

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date