Pharmacy Prior Authorization

AETNA BETTER HEALTH VIRGINIA CCC PLUS and MEDALLION/FAMIS 4.0

Steroids Non-Preferred (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 Virginia CCC Plus and Medallion/FAMIS 4.0 at **1-855-799-2553**.
When conditions are met, we will authorize the coverage of Steroids Non-Preferred (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Sernivo (betamethasone dipropionate spray)

Other, please specify_____

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:**_____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 5.]

2. Has the patient had a response to treatment? Y N

   [If no, then no further questions.]

3. Is this request for Sernivo? Y N

   [If no, then no further questions.]

4. Is this request for treatment beyond 4 weeks? Y N

   [No further questions.]

5. Is the patient unable to take a preferred product within the same class for any of the following reasons: A) Allergy to a preferred drug, B) Contraindication to or drug-to-drug interaction with a preferred drug, C) History of unacceptable/toxic side effects with a preferred drug, D) Patient's condition is clinically stable; changing to a preferred drug might cause deterioration of the patient's condition? Y N

   Please list the condition(s), interacting drug(s) or allergies:
   _____

   [If yes, then go to question 9.]

6. Has the patient experienced an inadequate treatment response of at least two preferred products within the same class? Y N

   Please list the name of the drug(s) tried: _____

   [If no, then no further questions.]

7. Does the requested drug have a corresponding generic available on the formulary? Y N

   [If no, then skip to question 9.]

8. Has the patient experienced an inadequate treatment response, intolerance, or contraindication to the generic? Y N

   [If no, then no further questions.]

9. Is this request for Sernivo? Y N

   [If no, then no further questions.]

10. Is Sernivo being prescribed for the treatment of mild to moderate plaque psoriasis? Y N

    [If no, then no further questions.]

11. Is the patient 18 years of age or older? Y N

Comments:

_____

_____

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

_____

Prescriber (Or Authorized) Signature **Date**