08/06/2015

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Long Acting Opioids (IL88)

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 Illinois Medicaid at **1-844-242-0908**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Long Acting Opioids (IL88).
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: _____

Please circle the appropriate answer for each question.

1. Does the patient have pain due to malignancy (cancer) or pain due to sickle cell anemia? Y N

   [If no, then skip to question 5.]

2. Is this request for one of the following medications: fentanyl patch, morphine sulfate ER, methadone, or OxyContin? Y N

   [If yes, then no further questions.]

3. Has this plan 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 15.]

4. Is the patient responding to medication? Y N

   [No further questions.]

5. Does the patient have a treatment plan that includes the diagnosis and goals of therapy? Y N

   [If no, then no further questions.]

6. Has the prescriber completed an addiction risk assessment for the specific therapy? Y N

   [If no, then no further questions.]

7. Has the prescriber recently reviewed the state Prescription Monitoring Program (PMP) database for this patient? Y N

   [If no, then no further questions.]

8. Does the patient have a pain management contract that addresses the following? Y N

   Consequences of unexplained loss or shortage of medications \ Consequences of obtaining similar prescription medications from other prescribers \ An agreement with the patient to only use one pharmacy

   [If no, then no further questions.]

9. Is this request for one of the following medications (fentanyl patch, morphine sulfate ER, or methadone)? Y N

   [If yes, then no further questions.]

10. Has this plan 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 12.]

11. Is the patient responding to medication? Y N

    [No further questions.]

12. Is this a request for Nucynta ER for the treatment of diabetic peripheral neuropathy? Y N

[If no, then skip to question 14.]

13. Has the patient failed an adequate trial (at least 4 weeks at maximum tolerated doses) of duloxetine AND tramadol AND at least ONE additional formulary medication (i.e., gabapentin, amitriptyline, nortriptyline, or topical capsaicin) for diabetic neuropathy? Please list medications tried and reason for treatment failure: Y N

_____

[If no, then no further questions]

[If yes, then skip to question 18.]

14. Is this request for the treatment of chronic pain? Y N

[If no, then no further questions]

15. Has the patient failed trials of at least 2 weeks each of maximum tolerated doses of at least TWO of the following formulary long-acting opioids: fentanyl patch, morphine sulfate ER, or methadone? Please list medications tried and reason for treatment failure: Y N

_____

[If no, then no further questions]

16. Is this request for Oxymorphone ER? Y N

[If yes, then skip to question 18.]

17. Has the patient failed a trial of at least 2 weeks at maximum tolerated doses of oxymorphone ER? Y N

[If no, then no further questions]

18. 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