08/06/2015

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Non-Formulary Diabetic Strips and Machines (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 **1-855-684-5250**.
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 Non-Formulary Diabetic Strips and Machines (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)
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 this plan authorized this product in the past for this patient (e.g. previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Is the patient responding to therapy? Y N

   [No further questions.]

3. Is this a request for a quantity limit exception on a formulary test strip product? Y N

   [If yes, then skip to question 9.]

4. Is this a request for a quantity limit on a formulary glucometer? Y N

   [If no, then skip to question 6.]

5. Does the patient meet one of the following: Y N

   Current glucometer is unsafe, inaccurate, or no longer appropriate based on patient's medical condition \
   Current glucometer no longer functions properly, has been damaged, or was lost or stolen

   [No further questions.]

6. Does the patient require the requested non-formulary product because the hematocrit level is chronically less than 30% or greater than 55%? If yes, please document hematocrit levels Y N

   _____

   [If yes, then skip to question 8.]

7. Does the patient have a physical limitation such as manual dexterity or visual impairment issues that limits utilization of a formulary product? If yes, please document limitation here: Y N

   _____

   [If no, then no further questions.]

8. Is the quantity requested greater than 150 test strips per 30 days? Y N

   [If no, then no further questions.]

9. Does the patient meet at least one of the following: Y N

   Newly diagnosed diabetic \ Gestational diabetic \ Child 12 years of age or younger \ On insulin pump \ On intensive insulin therapy

Comments:

_____

_____

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

_____

Prescriber (Or Authorized) Signature Date