Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

SGLT2 Inhibitors (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 Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of SGLT2 Inhibitors (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name

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. Is the patient CURRENTLY taking metformin? Y N

   [If yes, then skip to question 4.]

2. Did the patient have a previous inadequate response or adverse effect to metformin? Y N

   Please explain reason for metformin failure:

   _____

   [If yes, then skip to question 4.]

3. Does the patient have any of the following contraindications to metformin: A) Renal dysfunction (serum creatinine greater than 1.4mg per dL for females or greater than 1.5mg per dL for males), B) Y N

Metabolic acidosis, C) Diabetic ketoacidosis?

Please list contraindication(s):

_____

[If no, then no further questions]

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

   [If no, then no further questions.]

5. Is this request for a formulary preferred agent? (refer to formulary for a list of preferred agents) Y N

   [If yes, then no further questions.]

6. Has the patient had a trial and failure of a formulary preferred SGLT2 Inhibitor? (refer to formulary for a list of preferred agents) Y N

   Please list medications tried and reason for medication failure:

   _____

Comments:

_____

_____

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

_____

Prescriber (Or Authorized) Signature Date