

Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

HIV Duplicative Use (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 HIV Duplicative Use (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. According to pharmacy claims records the requested medication represents a therapeutic duplication with an existing antiretroviral drug the patient may be taking. Will the duplicative drug be discontinued? 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 \_\_\_\_\_