Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

PPI (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 PPI (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. 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 8.]

2. Has the patient previously been treated with high dose PPI? Y N

   [If no, then skip to question 4.]

3. Has the patient failed step-down to once daily dosing after completion of high dose course? Y N

Please provide rationale for continued high dose:

_____

[No further questions.]

4. Is this a request for a quantity limit exception (high dose)? (Refer to formulary for quantity limits) Y N

   [If no, then skip to question 7.]

5. Does the patient have the diagnosis of Barrett's esophagus, Esophageal stricture or Zollinger-Ellison syndrome? Y N

   [If yes, then no further questions.]

6. Did the patient have unsatisfactory or partial response to once daily dosing or continues with night-time symptoms? Y N

   [No further questions.]

7. Is the patient responding to therapy? Y N

   [No further questions.]

8. Is this request for one of the following agents: Prevacid SoluTab, Prilosec granules, Aciphex sprinkles, Protonix granules or Nexium granules (suspension)? Y N

   [If no, then skip to question 11.]

9. Is the patient unable to swallow tablets/capsules or is using a feeding tube for medications? Y N

   [If no, then no further questions.]

10. Has the patient had a trial and failure with BOTH First-omeprazole and First-lansoprazole? Y N

    [No further questions.]

11. Is this request for one of the following agents: Dexilant, esomeprazole (Rx) or omeprazole/sodium bicarbonate? Y N

12. Has the patient failed a trial of at least TWO formulary PPIs (proton pump inhibitors)? (Refer to formulary for Y N

preferred agents)

Please document medications tried:

_____

[If no, then further questions.]

13. Has the patient failed a trial of one additional formulary PPI at double the usual starting dose (i.e., omeprazole 40mg, Nexium OTC 40mg, lansoprazole 30mg, pantoprazole 40mg, rabeprazole 40mg.) Y N

    Please document medication tried:

    _____

    [If no, then no further questions.]

14. Is this a request for a quantity limit exception (high dose)? (Refer to formulary for quantity limits) Y N

    [If no, then no further questions.]

15. Does the patient have the diagnosis of Barrett's esophagus, Esophageal stricture or Zollinger-Ellison syndrome? Y N

    [If yes, then no further questions.]

16. Did the patient have unsatisfactory or partial response to once daily dosing or continues with night-time symptoms? 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