Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Tranexamic Acid (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 Tranexamic Acid (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Tranexamic acid tablets

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 Aetna Better Health 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 3.]

2. Has the patient had a significant decrease in menstrual bleeding? Y N

   [No further questions.]

3. Is the medication requested to treat cyclic heavy menstrual bleeding? Y N

   [If no, then skip to question 8.]

4. Has the patient had a trial and failure of, or is unable to take oral NSAIDs (non-steroidal anti-inflammatory drugs)? Y N

   [If no, then no further questions.]

5. Has the patient had a trial and failure of, or is unable to take ANY of the following: A) Oral combination hormonal cycle agents, B) Oral progesterone, C) Mirena, D) medroxyprogesterone injection (Depo-Provera), E) Progesterone-containing IUD? Y N

   If yes, please list which agents have been tried:

   _____

   [If no, then no further questions.]

6. Does the patient have any of the following: A) History of thrombosis or thromboembolism, B) Concurrent use of combination hormonal contraception? Y N

   [If yes, then no further questions.]

7. Is the patient 12 years of age or older? Y N

   [No further questions.]

8. Is the medication requested to treat or prevent acute bleeding episodes in a patient with hemophilia? 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