04/28/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Duloxetine (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 Duloxetine (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)

Duloxetine

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: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

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

   [If no, then no further questions.]

2. Does the patient have a diagnosis of Fibromyalgia Syndrome (FMS)? Y N

   [If yes, then no further questions.]

3. Does the patient have the diagnosis of depression? Y N

   [If no, then skip to question 5.]

4. Has the patient met ALL of the following: Y N

A trial and an inadequate treatment response with venlafaxine AND \ A trial and an inadequate treatment response with an SSRI antidepressant?

[No further questions.]

5. Does the patient have the diagnosis of neuropathic pain? Y N

   [If no, then skip to question 7.]

6. Has the patient had at least a two month trial and an inadequate treatment response to a formulary medication (e.g., venlafaxine, amitriptyline, topical capsaicin, tramadol or gabapentin)? Y N

   [No further questions.]

7. Does the patient have the diagnosis of generalized anxiety disorder (GAD)? Y N

   [If no, then skip to question 9.]

8. Has the patient had at least a two consecutive month trial of escitalopram, paroxetine, OR venlafaxine ER? Y N

   [No further questions.]

9. Does the patient have the diagnosis of chronic musculoskeletal pain (I.e., chronic low back pain or chronic pain caused by osteoarthritis)? Y N

   [If no, then no further questions.]

10. Has the patient had at least a two consecutive month trial of formulary NSAIDs OR documented contraindication to use of NSAIDs? 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