9/01/2013

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS

Elidel (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 at 1-855-684-5250.
Please contact Aetna Better Health Illinois at 1-866-212-2851 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Elidel (IL88).

Drug Name (select from list of drugs shown)

Elidel (pimecrolimus) cream

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. Does the patient require Elidel for short-term treatment of Eczema or Atopic dermatitis? Y N

   [If the answer to this question is no, then no further questions are required.]

2. Is this request for renewal authorization? Y N

   [If the answer to this question is no, then skip to question 4]

3. RENEWAL REQUESTS: Do the clinical notes support a response to a previous course of treatment? Y N

   (Note: If no improvement occurs after 6 weeks of treatment, treatment should be stopped and other therapeutic options considered)

   [No further questions are required.]

4. INITIAL AUTHORIZATION REQUESTS: Has the patient demonstrated failure of, OR intolerance to, two (2) different formulary topical corticosteroids (e.g., hydrocortisone, amcinonide, betamethasone, clobetasol, desoximetasone, fluocinolone, triamcinolone)? Y N

   If yes, please document medications tried and reason for treatment failure: _____

   [If the answer to this question is yes, then no further questions are required.]

5. Are topical corticosteroids contraindicated for this patient (e.g., periorbital/eyelid use)? Y N

   If yes, please document contraindications:

   _____

   [If the answer to this question is yes, then no further questions are required.]

6. Is the affected area on the face, but not around the eyes/eyelids? Y N

   [If the answer to this question is no, then no further questions are required.]

7. Has the patient failed a trial of one (1) low-potency topical corticosteroid (e.g., hydrocortisone, alclometasone, desonide)? Y N

   If yes, please document medications tried and reason for treatment failure: _____

Comments:

_____

_____

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

_____

Prescriber (Or Authorized) Signature Date