12/30/2015

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Cambia (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 **1-844-242-0908**.
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 Cambia (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)

Cambia (diclofenac potassium powder) 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. Does the patient have a diagnosis of migraine headaches? Y N

   [If no, then no further questions.]

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

   [If no, then no further questions.]

3. Has the patient tried and failed at least 2 formulary NSAIDs (i.e., ibuprofen, naproxen, diclofenac)? Please document NSAIDs tried: Y N

   [If yes, then no further questions.]

4. Has the patient tried and failed at least 2 formulary triptans (i.e., sumatriptan, naratriptan)? Please document triptans tried: Y N

_____

[If yes, then skip to question 6.]

5. Does the patient have a contraindication to triptans? If yes, please provide details: Y N

_____

[No further questions.]

6. Is the request for more than 9 packets per month? Please document rationale for exceeding quantity limit: 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