08/26/2015

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Duavee (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 Duavee (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (specify drug)

Duavee (conjugated estrogens-bazedoxifene)

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. Is the patient an adult female with an intact uterus? Y N

   [If no, then no further questions]

2. Is the requested drug being prescribed for the treatment of vasomotor symptoms associated with menopause? Y N

   [If no, skip to question 4]

3. Has the patient experienced an inadequate treatment response or intolerance to at least 2 formulary estrogen/progesterone products (e.g., estradiol tablets/patch, Prempro, Estrace)? List formulary agents trialed: Y N

[No further questions]

4. Is the requested drug being prescribed for the prevention of postmenopausal osteoporosis? Y N

   [If no, then no further questions]

5. Is the patient at significant risk of osteoporosis? Y N

   [If no, then no further questions]

6. Does the patient meet one of the following: Y N

   Experienced an inadequate treatment response or intolerance to raloxifene \ Has a history of venous thromboembolism (VTE) which is a contraindication to raloxifene

   [If no, then no further questions]

7. Does the patient meet one of the following: Y N

   Experienced an inadequate treatment response or intolerance to alendronate \ Has one of the following contraindications to alendronate: [Esophageal abnormalities \ Inability to stand or sit upright for 30 minutes \ Has additional risk factors for developing osteonecrosis of the jaw \ CrCl less than 35 mL/min]

Comments:

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

Prescriber (Or Authorized) Signature Date