Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Non-Calcium Based Phosphate Binders (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 Non-Calcium Based Phosphate Binders (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (specify drug)

Fosrenol Chew Tab (lanthanum carbonate)   Fosrenol Pow (lanthanum carbonate)
Velphoro (sucroferric oxyhydroxide)   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. Is the requested drug being prescribed for the treatment   Y   N
   of hyperphosphatemia (elevated phosphate) due to
   ESRD (end stage renal disease)?

   [If no, then no further questions]

2. Is the patient receiving dialysis?   Y   N

   [If no, then no further questions]

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

   [If no, then no further questions]

		Y	N

4. Has the patient experienced an inadequate treatment response to Renvela or Renagel (sevelamer) AND a calcium-based phosphate binder?

   [If yes, then no further questions]

5. Does the patient have a contraindication to Renvela or Renagel (sevelamer) AND calcium-based phosphate binders? Please specify contraindication if applicable:

   _____

Comments:

_____

_____

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

_____

Prescriber (Or Authorized) Signature   Date