Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

ADD-ADHD Non-Stimulants (Medicaid)

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 **1-844-242-0908**.
When conditions are met, we will authorize the coverage of ADD-ADHD Non-Stimulants (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Clonidine ER 0.1mg
Guanfacine ER
Kapvay 0.2mg (clonidine ER)
Strattera (atomoxetine)
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. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 4.]

2. Is the patient responding to medication? Y N

   [If no, then no further questions]

3. Is this a request for additional quantity since the last prior authorization approval? Y N

[If yes, then skip to question 17.]

4. [If no, then no further questions.] Y N

   Does the patient have a documented diagnosis of ADHD / ADD?

   [If no, then no further questions.]

5. Has the patient had an unsatisfactory improvement in core symptoms of ADHD on the maximum dose of at least 2 formulary stimulants? Y N

   If yes, please document name and dose of stimulants tried:

   _____

   [If yes, then skip to question 7.]

6. Has the patient had a known history of intolerable adverse effects from stimulants OR is the patient a poor candidate for stimulants (i.e., tic disorder, substance use disorder, MI, hypertension, hyperthyroidism)? Y N

   If yes, please document adverse effects experienced or reason for avoiding stimulants:

   _____

   [If no, then no further questions.]

7. Have other behavioral health conditions (such as depression, anxiety, conduct disorders, or substance use) been ruled out? Y N

   [If no, then no further questions.]

8. Is the patient between the ages of 6 to 17 years? Y N

   [If no, then skip to question 13.]

9. Was the diagnosis of ADHD/ADD based on a comprehensive evaluation by an appropriate specialist or primary care provider using an evidence based rating scale such as the Connors, Behavior Assessment System for Children (BASC), or the Child Behavior Checklist/Teacher Report Form? Y N

   If yes, please document scale used:

   _____

   [If no, then no further questions.]

10. Is the patient actively participating in an evidence-based behavioral therapy? Y N

If yes, please document type of therapy:

_____

[If no, then no further questions.]

11. Is this request for guanfacine ER, clonidine ER, or Kapvay 0.2mg? Y N

[If no, then skip to question 15.]

12. Is the patient currently taking mirtazapine? Y N

[If no, then go to question 17.]

[If yes, then no further questions.]

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

[If no, then no further questions.]

14. Was the diagnosis of ADHD/ADD based on a comprehensive evaluation by an appropriate specialist using the current DSM (Diagnostic and Statistical Manual of Mental Disorders) criteria and an evidence based rating scale such as the Connors or Adult Self-Report Scale-V1.1 (ASRS-V1.1)? Y N

If yes, please document scale used:

_____

[If no, then no further questions.]

15. Is this request for Strattera? Y N

[If no, then no further questions.]

16. Is the patient currently taking a CNS stimulant? Y N

[If yes, then no further questions.]

17. Is the requested dose greater than FDA recommended maximum daily dosage? Y N

If yes, please submit clinical evidence of safety and efficacy from peer-reviewed journal articles.

[If yes, then no further questions.]

18. Is this request for quantity limit exception? (Refer to formulary for covered quantity.) Y N

[If no, then no further questions.]

19. Is the dosing based on inability to swallow optimal dose? Y N

    [If yes, then no further questions.]

20. Is the dosing due to patient ability to not tolerate total daily dose in one administration? Y N

    [If yes, then no further questions.]

21. Can the prescribed total daily dose be achieved with a lower quantity of a higher strength that does not exceed the quantity limit (e.g. one 60mg tablet/day in place of two 30 mg tablets/day)? Y N

    If no, please provide reason:

    _____

    [Note: Dose Optimization, use of a higher strength to allow a patient to take fewer doses to achieve the same total daily dose.]

Comments:

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

Prescriber (Or Authorized) Signature Date