Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Antidepressants Non-Formulary (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 Antidepressants Non-Formulary (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name

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 patient currently taking this medication? Y N

   If yes, please specify how patient has been receiving medication (insurance, samples, paying out of pocket):

   _____

   [If no, then skip to question 3.]

2. Is the patient responding to therapy with this medication? Y N

   [If yes, then skip to question18.]

   [If no, then no further questions.]

3. Does the patient have Major Depressive Disorder or Seasonal Affective Y N

Disorder?

[If no, then skip to question 10.]

4. Did the patient experience treatment failure or intolerable side effects with 3 antidepressants from at least 2 different classes (SSRI, SNRI, bupropion, or mirtazapine) at an adequate dose and duration (at least 4 weeks)? Y N

   If yes, please list medications and doses tried:

   _____

   [If yes, then skip to question 6.]

5. Did the patient experience treatment failure or intolerable side effects with trials of TWO different antidepressants AND an acceptable antidepressant augmentation regimen at an adequate dose and duration (at least 4 weeks)? Y N

   Note: Acceptable augmentation regimens include an SSRI or SNRI plus one of the following: bupropion, lithium, atypical antipsychotic, buspirone, or liothyronine.

   If yes, please list medications and doses tried:

   _____

   [If no, then no further questions.]

6. Is the request for Trintellix or Viibryd? Y N

   [If no, then skip to question 8.]

7. Was one of the antidepressant trials with a preferred formulary SSRI such as sertraline, citalopram, escitalopram, fluoxetine, or paroxetine? Y N

   [If yes, then skip to question18.]

   [If no, then no further questions.]

8. Is the request for Fetzima? Y N

   [If no, then skip to question 16.]

9. Was one of the antidepressant trials with a preferred formulary SNRI such as venlafaxine or duloxetine? Y N

   [If yes, then skip to question18.]

   [If no, then no further questions.]

10. Does the patient have Obsessive-Compulsive Disorder? Y N

    [If no, then skip to question 12.]

11. Did the patient experience treatment failure or intolerable side effects with 3 other antidepressants (e.g., SSRI's, clomipramine) at an adequate dose and duration (at least 4 weeks)? Y N

    If yes, please list medications and doses tried:

    _____

    [If yes, then skip to question 16.]

    [If no, then no further questions.]

12. Does the patient have hot flashes associated with menopause? Y N

    [If no, then skip to question 14.]

13. Did the patient experience treatment failure or intolerable side effects with, or has a clinical reason to avoid, hormonal therapy? Y N

    [If yes, then skip to question 15.]

    [If no, then no further questions.]

14. Does the patient have Panic Disorder or Generalized Anxiety? Y N

    [If no, then no further questions.]

15. Did the patient experience treatment failure or intolerable side effects with 3 antidepressants from at least 2 different classes (SSRIs or SNRIs) at an adequate dose and duration (at least 4 weeks)? Y N

    If yes, please list medications and doses tried:

    _____

    [If no, then no further questions.]

16. Is the request for Pexeva, Aplenzin, Forfivo XL, fluvoxamine ER, paroxetine mesylate capsule, fluoxetine weekly, venlafaxine SR tablets, or paroxetine ER? Y N

    [If no, then skip to question18.]

17. Has the patient experience treatment failure or intolerable side effects with a formulary preferred product with the same active ingredient? Y N

    [If no, then no further questions.]

18. Does the prescribed dose and/or dosing interval/frequency exceed the manufacturer's published package labeling? Y N

    If yes, provide dose and frequency and reason for exceeding the maximum dose or dosing frequency:

    _____

Comments:

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

Prescriber (Or Authorized) Signature Date