

Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Diclegis (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 Diclegis (Medicaid).

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

Drug Name *(please circle)*

Diclegis (doxylamine/pyridoxine)

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 Aetna Better Health 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 3.]

2. Does the patient continue to have nausea and vomiting during the pregnancy? Y N

[No further questions]

3. Does the patient have a diagnosis of nausea and vomiting in pregnancy? Y N

[If no, then no further questions.]

- | | | |
|--|---|---|
| 4. Has the patient had an inadequate response or intolerable side effects to dietary and lifestyle changes (e.g., avoiding stimuli/triggers, avoiding spicy and fatty foods, eating frequent small meals, an inadequate response to ginger)? | Y | N |
|--|---|---|

[If no, then no further questions.]

- | | | |
|--|---|---|
| 5. Has the patient had an inadequate response or intolerable side effects to a combination of OTC doxylamine and OTC pyridoxine (vitamin B6) AND at least 1 of the following: H1 antihistamines (e.g., diphenhydramine, meclizine, dimenhydrinate) or ondansetron? | Y | N |
|--|---|---|

[If no, then no further questions.]

- | | | |
|---|---|---|
| 6. Is the patient 18 years of age or older? | 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