Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Lidocaine Patch 5% (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 Lidocaine Patch 5% (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

lidocaine patch 5%

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 with this plan)? Y N

   [If no, then skip to question 3.]

2. Has the patient had a response to treatment? Y N

   [No further questions.]

3. Does the patient have post-herpetic neuralgia (PHN)? Y N

   [If yes, then no further questions.]

4. Does the patient have diabetic peripheral neuropathy (DPN)? Y N

   [If no, then no further questions.]

5. Has the patient had a documented trial and failure or intolerance to 2 formulary alternatives (e.g., duloxetine, tricyclic antidepressants, gabapentin)? Y N

   Please list medications tried:

   _____

   [If no, then no further questions.]

6. Is the patient 17 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