Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

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

Drug Name *(please circle)*

Multaq (dronedarone)

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 Multaq being prescribed by or in consultation with a cardiologist? Y N

   [If no, then no further questions.]

2. Does the patient have paroxysmal or persistent atrial fibrillation? Y N

   [If no, then no further questions.]

3. Is the patient currently in normal sinus rhythm OR is it planned to cardiovert the patient to achieve normal sinus rhythm? Y N

   [If no, then no further questions.]

4. Has the patient experienced an inadequate treatment response or intolerable side effects to amiodarone, propafenone, flecainide, or sotalol, or has contraindications to all? Y N

   [If no, then no further questions.]

5. Has the provider reviewed the REMS requirements and confirmed that the patient is appropriate for Multaq? Y N

   [If no, then no further questions.]

6. Has the provider confirmed that the patient is not taking any medications that should not be used with Multaq? Y N

   Note: Patient should not be taking Statin greater than 10mg, sirolimus, tacrolimus, Class I/III antiarrhythmics.

   [If no, then no further questions.]

7. 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