Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Oncology Antineoplastic Agents (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 Oncology Antineoplastic Agents (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. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? [If no, skip to question 5] Y N
2. Has the patient had clinically significant improvement or stabilization of the disease state? [If no, then no further questions] Y N
3. Is adverse effect monitoring being done as recommended in the FDA-approved label? [If no, then no further questions] Y N
4. Is the dose of the medication being adjusted as needed for adverse effects based on the FDA-approved level? Y N

[No further questions.]

5. Is the medication being prescribed for an FDA-approved indication? Y N
   [If yes, skip to question 7]

6. Is the medication being prescribed for a "medically accepted indication" as noted in any of the following Compendia? A) NCCN Drugs and Biologic Compendium or NCCN Clinical Practice Guidelines, category 1, 2a, or 2b, B) Micromedex DrugDex, or C) Clinical Pharmacology. Y N
   [If no, then no further questions]

7. Is the patient under the care of an oncologist? Y N
   [If no, then no further questions]

8. Have medical records, lab results, test results, and clinical markers supporting the diagnosis and treatment been submitted with the request? Y N
   [If no, then no further questions]

9. Does the patient have any contraindications to the requested medication OR is the patient taking other medications that should be avoided with the requested drug based on the FDA-approved labeling? Y N
   [If yes, then no further questions]

10. Is the request for experimental/investigational use or for a patient enrolled in a clinical trial for the condition being treated by the requested drug? Y N
    [If yes, then no further questions]

11. Does the prescribed dose fall within the FDA-approved range for the indication and patient specific factors (e.g., age, weight or BSA, renal function, liver function, drug interactions, etc)? Y N
    [If no, then no further questions]

12. Is the requested medication a formulary preferred product? Y N
    [If yes, then no further questions]

13. Were trials of formulary preferred agents for an adequate duration not effective or poorly tolerated? Y N
    [If yes, then no further questions]

14. Are all other formulary preferred alternatives contraindicated based on the patient's other medical conditions or drug interactions? Y N
    [If yes, then no further questions]

15. Is the request for treatment of an indication for which there are no Y N

formulary preferred medications?
[If yes, then no further questions]

16. Does the patient have a genetic mutation that is resistant to the formulary preferred agents? 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