Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

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

Drug Name *(please circle)*

(enoxaparin) (Fondaparinux) Fragmin (dalteparin)

Iprivask (desirudin)

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 this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   If yes, please provide following:
   Rationale for continued treatment: _____
   Anticipated length of therapy: _____
   Indication: _____
   Recent INR if on warfarin: _____

   [If yes, then no further question.]

2. Is this a request for enoxaparin, fondaparinux, or Fragmin? Y N

   [If no, then skip to question 16.]

3. Is the requested drug being prescribed for prevention of venous thromboembolism (VTE) in a patient who is having hip or knee replacement or hip fracture surgery? Y N

   Please document date of surgery: _____

   [If yes, then no further questions.]

4. Is the requested drug being prescribed for a patient who recently started warfarin and has not achieved a therapeutic INR for at least 2 days or for a patient who requires warfarin bridging for a surgery? Y N

   Please provide recent INR values: _____
   Please provide surgery date (if applicable): _____

   [If yes, then no further questions.]

5. Is the requested drug being prescribed for treatment or prevention of thrombotic complications during pregnancy? Y N

   Please provide patient's estimated due date: _____
   The duration of approval is based on the due: _____
   The duration of approval is based on the due date of the pregnancy plus 6 weeks.

   [If yes, then no further question]

6. Is the requested drug being prescribed for prevention of venous thromboembolism (VTE) in a patient who has restricted mobility during acute illness? Y N

   [If yes, then no further questions]

7. Is the requested drug being prescribed to treat superficial vein thrombosis (SVT) of the lower limb? Y N

   [If yes, then no further questions]

8. Is the requested drug being prescribed to treat an acute upper-extremity deep vein thrombosis (UEDVT)? Y N

   [If yes, then no further questions]

9. Is the requested drug being prescribed for recurrent venous thromboembolism (VTE) while taking oral anticoagulants? Y N

   [If yes, then no further questions.]

10. Is this a request for enoxaparin or Fragmin prescribed for prevention of or to treat an active venous thromboembolism (VTE) in a patient with cancer? Y N

    [If yes, then no further questions]

11. Is this a request for enoxaparin or Fragmin prescribed for treatment of venous thromboembolism (VTE) in a patient who has had a treatment failure with warfarin and Eliquis, Pradaxa or Xarelto? Y N

    [If yes, then no further questions]

12. Is this a request for enoxaparin or Fragmin prescribed for prevention of venous thromboembolism (VTE) in a patient with atrial fibrillation who will be having cardioversion? Y N

    If yes, please provide date of cardioversion:
    _____

    [If yes, then no further questions.]

13. Is this a request for enoxaparin or Fragmin prescribed for prevention of venous thromboembolism (VTE) in a patient with acute ischemic stroke and has restricted mobility? Y N

    [If yes, then no further questions.]

14. Is this a request for enoxaparin or Fragmin prescribed for prevention of venous thromboembolism (VTE) in a patient undergoing surgery (i.e. abdominal-pelvic or general) and is at high risk for VTE? Y N

    If yes, please provide date of surgery: _____

    [If yes, then no further questions.]

15. Is this a request for enoxaparin or Fragmin prescribed for prevention of venous thromboembolism (VTE) in a patient who has had recent major trauma? Y N

    [If yes, then no further questions]
    [If no, then no further questions]

16. Has the patient had an inadequate response or intolerance for at least 4 weeks at maximum tolerated doses to one additional formulary medication (e.g., gabapentin, amitriptyline, nortriptyline, or topical capsaicin)? Y N

    [If no, then no further questions]

17. Has the patient had a therapeutic failure or intolerance to enoxaparin or Fragmin AND fondaparinux? Y N

    [If yes, then no further questions]

18. Does the patient have one of the following contraindications to enoxaparin, fondaparinux, and Fragmin: pork allergy or history of heparin induced thrombocytopenia? 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