09/25/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)
Hemophilia Medications (IL88)
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 Medicaid at **1-844-242-0908**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Hemophilia Medications (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (specify drug)

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: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Is the drug being prescribed for an FDA approved diagnosis/indication OR a diagnosis/indication supported in an established compendia? Please document diagnosis/indication here: Y N

   [Note: Requests for Non-Formulary Medications will be reviewed upon receipt of clinical documentation in the form of progress notes, consult notes, and supporting laboratory data. A prior authorization form submitted without supporting documentation that does not have adequate information for review and will not be approved.]

   [If no, then no further questions.]

2. Is the drug being prescribed at a medically accepted dose based on age and indication? Please document dose and patient age here — Y N

   [If no, then no further questions.]

3. Has Aetna Better Health Plan authorized this medicine in the past for this patient (e.g. previous authorization is on file under Aetna Better Health Plan)? — Y N

   [Note: Clinical notes will be required for reauthorization]

   [If no, then skip to question 5.]

4. Is the requested drug a maintenance medication? — Y N

5. Does the patient have a documented trial and failure of at least 2 formulary agents for an adequate duration or have formulary agents not been effective or tolerated? Please document trial formulary agents here: — Y N

   [If yes, then no further questions.]

6. Are all other formulary medications contraindicated based on the patient's diagnosis, other medical conditions or other medication therapy? Please document reason for contraindication here: — Y N

   [If yes, then no further questions.]

7. Are there no other medications available on the formulary to treat the patient's condition? — 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