09/25/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)
Nucynta ER (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 Nucynta ER (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Nucynta ER (tapentadol extended-release)

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

   [If no, then skip to question 3.]

2. Is the patient having a response to treatment? Y N

   [No further questions.]

3. Is the patient 18 years of age or older? Y N

4. Does the patient have a diagnosis of diabetic neuropathic pain? Y N

   [If no, then skip to question 7.]

5. Has patient had a trial and failure of two formulary medications such as, gabapentin, tricyclic antidepressants (amitriptyline, nortriptyline), tramadol, or topical capsaicin? Please list medication tried and reason for treatment failure — Y N

6. Has patient had a trial and failure of duloxetine OR Lyrica? Please list medication tried and reason for treatment failure — Y N

[No further questions.]

7. Does the patient have a diagnosis of chronic pain? — Y N

8. Has patient had a trial and failure of maximum tolerated dose of two formulary long-acting agents (i.e., fentanyl patch, morphine sulfate ER, methadone) OR a contraindication to formulary long-acting agents? Please list medication tried and reason for treatment failure — Y N

9. Has patient had a trial and failure of OxyContin OR a contraindication to OxyContin? Please list reason for treatment failure — 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