05/20/2015

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Egrifta (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 **1-855-684-5250**.
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 Egrifta (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)

Egrifta (tesamorelin) 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 no, skip to question 5.]

2. Is the patient responding to therapy with Egrifta (i.e., decreased baseline waist circumference): Please provide details of symptom improvement Y N

   _____

   [If no, no further questions.]

3. Has appropriate clinical monitoring (i.e., IGF-1, A1c) been completed since the last authorization was given? Y N

   [If no, no further questions.]

4. Is this the first renewal request after initial authorization? Y N

   [No further questions.]

5. Is Egrifta requested for weight loss (cosmetic use)? Y N

   [If yes, no further questions.]

6. Is Egrifta requested for the treatment of excess abdominal fat in an HIV-infected patient with lipodystrophy? Y N

   [If no, no further questions.]

7. Does the patient meet one of the following criteria? Y N

   For men: Waist circumference greater than or equal to 95 cm (37.4 inches) and a waist-to-hip ratio greater than or equal to 0.94 \ For women: Waist circumference greater than or equal to 94 cm (37.0 inches) and a waist-to-hip ratio greater than or equal to 0.88

   [If no, no further questions.]

8. Is the patient on antiretroviral therapy? Y N

   [If no, no further questions.]

9. Is the patient at risk for medical complications due to excess abdominal fat? Y N

   [If no, no further questions.]

10. Does the patient have any of the following contraindications to therapy? Y N

    Disruption of the hypothalamic-pituitary axis (e.g. hypothalamic-pituitary-adrenal (HPA) suppression) due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, radiation therapy of the head or head trauma, \ Active malignancy \ Known hypersensitivity to tesamorelin and/or mannitol \ Pregnancy

    [If yes, no further questions.]

11. Is the patient 18 to 65 years of age? Y N

    [If no, no further questions.]

12. Does the treatment plan include monitoring of IGF-1 and A1c? 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