05/20/2015

Prior Authorization Form

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Zorbtive (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 Zorbtive (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)

Zorbtive (somatropin) 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. Does the patient have a diagnosis of short bowel syndrome? Y N

   [If no, no further questions.]

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

   [If no, no further questions.]

3. Is the patient receiving specialized nutrition (eg, TPN or PPN)? Y N

   [If no, no further questions.]

4. Has the patient completed one four-week course of therapy with Zorbtive? 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