04/30/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Long Acting Opioids (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 Long Acting Opioids (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)

Butrans Patch (buprenorphine)
Exalgo (hydromorphone)
Opana ER (oxymorphone)
OxyContin (oxycodone)
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 request for OxyContin? Y N

   [If no, then skip to question 8.]

2. Is this a renewal request for a previous authorization of OxyContin? Y N

   [If no, then skip to question 4.]

3. Is the patient responding to OxyContin? Y N

   [No further questions.]

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

   [If no, then no further questions.]

5. Does the patient require more than 90 tablets of Oxycontin per 30 days? Y N

   [If yes, then no further questions.]

6. Is the OxyContin being prescribed for cancer-related pain? Y N

   [If yes, then no further questions.]

7. Has the patient had a trial and failure of maximum tolerated dose OR contraindication to two formulary long-acting agents (e.g., fentanyl patch, morphine sulfate ER, methadone)? Y N

8. Has the patient had a trial and failure of OxyContin? 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