05/02/2014

Prior Authorization Form

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Synarel (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 Synarel (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)

Synarel (nafarelin acetate nasal solution)

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. Does the patient have a diagnosis of Endometriosis? Y N

   [If no, skip to question 7.]

2. Is this a renewal request? Y N

   [If no, then skip to question 4.]

3. Is Synarel being used in combination with norethindrone acetate 5 mg daily AND does the patient have bone density (DEXA or BMD) values within normal limits? Y N

   [No further questions]

4. Has Synarel been prescribed by or in consultation with a gynecologist or obstetrician? Y N

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

6. Has the patient had a trial and failure of at least one formulary medication unless contraindicated (i.e., medroxyprogesterone or other hormonal cycle control agents such as Portia, Ocella)? Y N

   [No further questions.]

7. Does the patient have a diagnosis of Central Precocious Puberty (CPP)? Y N

8. Is this a renewal request? Y N

   [If no, skip to question 10.]

9. Has the patient had a clinical response to treatment (i.e., prepubertal slowing or decline, FSH, LH, Bone Age, or estradiol and testosterone level)? Y N

   [No further questions.]

10. Has Synarel been prescribed by or in consultation with an endocrinologist? Y N

11. Does the patient meet all of the following? Y N

    MRI or CT Scan has been performed to rule out lesions \ Onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males \ Response to a GnRH stimulation test (or if not available, other labs to support CPP) \ Bone age advanced 1 year beyond the chronological age

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**