Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Vecamyl (Medicaid)

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 Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Vecamyl (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Vecamyl (mecamylamine)

Other, specify drug _____

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:** _____

Circle the appropriate answer for each question.

1. Does the patient have a diagnosis of moderately severe to severe hypertension? Y N

   [If no, then no further questions.]

2. Does the patient have a documented history of failure to achieve blood pressure goals using maximum tolerated doses of at least 6 other classes of antihypertensive medications within the last 12 months? Y N

   [If no, then no further questions.]

3. Has the physician verified that the patient does NOT have any of the following conditions: A) Coronary insufficiency, B) Recent myocardial infarction, C) Y N

Rising/elevated blood urea nitrogen (BUN) or renal insufficiency, D) Uremia, E) Patient receiving concomitant antibiotics or sulfonamides, F) Glaucoma, G) Organic pyloric stenosis, H) Hypersensitivity to mecamylamine?

[If no, then no further questions.]

4. Is the request for continuation of therapy? Y N

   [If no, then no further questions.]

5. Does the patient have recent claim history of the requested drug (within the previous 3 months)? 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**