Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Epaned (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 Epaned (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Epaned (enalapril oral solution)

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 the diagnosis of hypertension, symptomatic heart failure or asymptomatic left ventricular dysfunction? Y N
2. Is the patient 12 years of age or older? Y N

   [If no, then no further questions]

3. Does the patient's medical record indicate a history of difficulty swallowing (dysphagia) or a medical condition that is characterized by difficulty or inability to swallow? 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