Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

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

Drug Name *(circle drug)*

erythromycin ethylsuccinate erythromycin stearate erythromycin base

erythromycin estolate

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. Is this request for a continuation in therapy? Y N

   [If yes, then skip to question 4]

2. Is the requested drug being prescribed for an infectious disease indication? Y N

   [If yes, then no further questions.]

3. Is the requested drug being prescribed for use in a patient with delayed gastric motility (e.g., diabetic gastroparesis, postsurgical gastroparesis)? Y N

[No further questions]

4. Does the patient continue to respond to erythromycin therapy? Y N

   [Note: The effectiveness of chronic therapy may be limited due to tachyphylaxis as a result of motion receptor downregulation. Clinical responsiveness to oral erythromycin declines after four weeks]

Comments:

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

Prescriber (Or Authorized) Signature Date