

Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Folic

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 Folic.

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

Drug Name

Folic (cyanocobalamin/folic acid/pyridoxine)

Other, please specify _____

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: _____

Please circle the appropriate answer for each question.

1. Is the patient pregnant? Y N
[Note: What is patient's expected date of delivery? _____]

The duration of approval is based on the expected date of delivery.]

2. Does the patient have a diagnosis of Methylene tetrahydrofolate reductase (MTHFR) deficiency verified by progress notes, discharge notes or diagnosis codes(s)? 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