Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

H.P. Arthar Gel

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

## Drug Name

H.P. Arthar Gel (repository corticotropin injection)

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. Does the patient have a diagnosis of West Syndrome (infantile spasms) verified by progress notes, discharge notes, or health conditions? Y N
   [If no, skip to question 3.]
2. Is the patient less than 2 years of age? Y N
   [If yes, skip to question 6.]
   [If no, no further questions.]

3. Does the patient have a diagnosis of multiple sclerosis verified by progress notes, discharge notes, or health conditions? [If no, no further questions.] Y N

4. Is the patient 18 years of age or older? [If no, no further questions.] Y N

5. Has the patient failed corticosteroid therapy (e.g. dexamethasone, hydrocortisone, methylprednisolone, prednisone)? [If no, no further questions.] Y N

6. Is the medication prescribed by a neurologist or a specialist in this field of study? 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