Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Hemangeol

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

Drug Name *(please circle)*

Hemangeol (propranolol oral solution)

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 this for an initial review of treatment with Hemangeol? Y N
   [If no, then skip to question 6.]
2. Does patient have a diagnosis of proliferating infantile hemangioma? Y N
   [If no, then no further questions]
3. Is the patient between the ages of 5 weeks (adjusted gestational age) and 5 months? Y N
   [If no, then no further questions]

4. Does the patient weigh a minimum of 2 kilograms? Y N
   [If no, then no further questions]

5. Does the patient have any of the following contraindications?
   - known hypersensitivity to propranolol or excipients
   - asthma or history of bronchospasm?
   - bradycardia (less than 80 beats per minute)
   - greater than first degree heart block
   - decompensated heart failure
   - blood pressure less than 50/30mmHg
   - pheochromocytoma

   [if yes, then no further questions.]

6. Has the patient had an initial successful treatment with Hemangeol for 6 months resulting in complete or nearly complete resolution of the target hemangioma but has experienced a reoccurrence? 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