Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Kapvay

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

Drug Name ***(please circle)***

Kapvay (clonidine hydrochloride extended-release tablets)

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 6 years of age or older? Y N
2. Does the patient have a diagnosis of Attention Deficit Hyperactivity Disorder? Y N
3. Does the patient have a contraindication to stimulant therapy? [If yes, skip to question 5.] Y N
4. Has the patient had a minimum trial of one month of a methylphenidate (i.e., Daytrana, Focalin XR,, Metadate) AND an amphetamine (i.e., Vyvanse, dextroamphetamine) product? Y N

5. Has the patient had a minimum trial of one month of Intuniv? Y N
6. Is this request for a continuation of therapy? 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**