

Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Lamictal XR

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 Lamictal XR.

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

Drug Name *(please circle)*

Lamictal XR (lamotrigine 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 Lamictal XR being prescribed for neuralgia, bipolar disorder, or migraines? Y N
[If yes, then no further questions.]

[Note: If yes, refer physician to lamotrigine (brand or generic) or other preferred alternatives.]

2. Is the patient 13 years of age or older? Y N
3. Does the patient have a seizure diagnosis verified by supporting documentation or billed diagnoses codes? Y N

4. Has the patient had a trial and failure of three preferred alternatives, which must include lamotrigine (brand or generic)? 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