Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Myrbetriq

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

Drug Name *(please circle)*

Myrbetriq (mirabegron)

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 18 years of age or older? Y N
   [If no, then no further questions.]
2. Does the patient have a diagnosis of overactive bladder? Y N
   [If no, then no further questions.]
3. Is the request for continuation of therapy? Y N
   [If yes, then no further questions.]
4. Has the patient had trial and failure within the past 365 days of at least two other indicated anticholinergic agents? 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