Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Nuplazid (Medicaid)

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

Drug Name ***(circle drug)***

Nuplazid (pimavanserin tartrate)

Other, specify drug ______________________________

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:**______________________________

Circle the appropriate answer for each question.

1. Is the patient 18 years of age? Y N

   [If no, no further questions.]

2. Does the patient have a diagnosis of Parkinson's disease? Y N

   [If no, no further questions.]

3. Does the patient have a diagnosis of Parkinson's disease psychosis manifesting hallucinations or delusions by a neurologist, psychiatrist or in consultation with a neurologist or psychiatrist? Y N

   [If no, no further questions.]

4. Has adjustment of medications been tried to reduce psychosis without worsening motor symptoms documented prior to request for Nuplazid? Y N

   [If no, no further questions.]

5. Is the request for continuation of therapy? Y N

   [If no, no further questions.]

6. Has there been an improvement in Parkinson's disease of hallucinations or delusions? Y N

Comments:

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I affirm that the information given on this form is true and accurate as of this date.

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Prescriber (Or Authorized) Signature **Date**