Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Onfi

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

Drug Name *(please circle)*

Onfi (clobazam)

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 2 years of age or older? Y N
2. Does the patient have a diagnosis of Lennox-Gastaut syndrome verified by progress notes, discharge notes, or health conditions? [If no, then skip to question 5.] Y N
3. Is the patient currently on an antiepileptic regimen which includes one of the following: valproate (divalproex sodium/ER, valproic acid, Depakene, Depakote, Depakote ER, Stavzor), Felbamate, Topamax, clonazepam, or Lamictal? Y N

4. Has the patient had a trial and failure of two preferred alternatives?
   [No further questions.] Y N

5. Does the patient have a diagnosis of seizures (verified in health conditions or progress notes) and medical documentation verifying a history of inadequately controlled seizures? Y N

6. Does the patient have a history of a trial and failure of multiple (at least 3) anticonvulsant mediations including benzodiazepines? Y N

7. Is Onfi being prescribed by a neurologist? 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