Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Otrexup

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

Drug Name

Otrexup (methotrexate auto-injector)

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, skip to question 6.]

2. Does the patient have active rheumatoid arthritis? Y N
   [If yes, skip to question 8.]

3. Does the patient have a diagnosis of severe, recalcitrant disabling psoriasis? Y N
   [If no, no further questions.]

4. Has the patient had an inadequate response to or is the patient not a candidate for a 3-month minimum trial of phototherapy (e.g., Psoralens with UVA light (PUVA) OR UVB with coal tar or dithranol? Y N

[If no, no further questions.]

5. Has the patient had an inadequate response, intolerance, or contraindication to all of the following: 1) methotrexate tablets and 2) methotrexate intramuscular injections? If yes, clinical documentation must be submitted demonstrating response to previous therapies. [No further questions.] Y N

6. Is the patient 2 years of age or older? [If no, no further questions.] Y N

7. Does the patient have a diagnosis of juvenile idiopathic arthritis? [If no, no further questions.] Y N

8. Has the patient had an inadequate response, intolerance, or contraindication to all of the following: 1) NSAIDs, 2) methotrexate tablets and 3) methotrexate intramuscular injections? If yes, clinical documentation must be submitted demonstrating response to previous therapies. 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**