Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

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

Drug Name *(circle drug)*

ProCentra (dextroamphetamine sulfate oral solution)

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 3 to 5 years of age? Y N

   [If no, then no further questions.]

2. Does the patient have a diagnosis of Attention Deficit Disorder with Hyperactivity? Y N

   [If no, then no further questions.]

3. Is the patient unable to swallow tablets as indicated by an absence of prescriptions for solid dosage forms (tablet or capsule) in claims history and/or medical records? Y N

[If no, then no further questions.]

4. Will the patient be titrated to a dose that is 40mg per day or less? Y N

   [If no, then no further questions.]

5. Has the patient had an intolerance to methylphenidate products? Y N

   Please submit official documentation of adverse response or reaction.

   [If yes, then no further questions.]

   If yes, please submit documentation of the adverse response or reaction for approval

   _____

6. Has the patient had a trial of at least one month of a methylphenidate product (e.g., Methylin Solution)? 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