Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

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

Drug Name *(please circle)*

Qudexy XR (topiramate extended release capsules)

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 Qudexy XR being prescribed for neuralgia, bipolar disorder or migraine prophylaxis? Y N

   [Note to provider: If yes, please refer to topiramate (brand or generic) or other preferred alternatives for these diagnoses.]

   [If yes, then no further questions]

2. Is patient 2 years of age or older? Y N

3. Is Qudexy XR being prescribed for treatment of Lennox-Gastaut Syndrome or adjunctive therapy with partial or primary generalized tonic-clonic seizures? Y N

[If yes, then skip to question 5]

4. Is Qudexy XR being prescribed for monotherapy with the diagnosis of partial onset or primary generalized tonic-clonic seizures? Y N

5. Has the patient had a trial and failure of topiramate and two other preferred medications? Y N

   Please list the name(s) of the drug(s) tried:

   _____

Comments:

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

Prescriber (Or Authorized) Signature Date