Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Sabril

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

Drug Name *(please circle)*

Sabril (vigabatrin)

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 prescribing provider a specialist in the neurology field of study? Y N
   [If no, no further questions.]
2. Does the patient have a diagnosis of refractory complex partial seizures confirmed via progress notes or “health conditions”? Y N
   [If yes, skip to question number 5.]
3. Does the patient have a diagnosis of infantile spasms confirmed via progress notes or “health conditions”? Y N
   [If no, no further questions.]

4. Is the patient one month to two years of age? Y N
   [If yes, skip to question number 7.]
   [If no, no further questions.]

5. Is the patient 10 years of age or older? Y N
   [If no, no further questions.]

6. Has the patient failed at least three preferred medications? Y N
   [If no, no further questions.]

7. Has official verification of compliance with the Sabril prescribing process as per the SHARE program been submitted, including both of the following? a) A copy of the completed SABRIL REMS Program/Parent/Legal Guardian-Physician Agreement Form AND b) Documentation indicating that periodic vision monitoring, as described in the Prescribing Information, is performed on an ongoing basis for each patient (baseline, no later than 4 weeks after starting Sabril and at least every 3 months while on therapy. Vision testing is also recommended about 3 to 6 months after the discontinuation of Sabril therapy) Y N

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