

Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Samsca (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 Samsca (Medicaid).

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

Drug Name *(please circle)*

Samsca (tolvaptan)

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, no further questions.]

2. Does the patient have a diagnosis of hyponatremia with ONE of the following? Y N

-Serum sodium level may be below 125 mEq/L OR

-Serum sodium level is 125 mEq/L or greater but patient is symptomatic and has resisted correction with fluid restriction

[If no, no further questions.]

3. Did the patient receive initial dose or re-initiation of therapy in the hospital? If yes, submit supporting documentation. 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