Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Saphris

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

Drug Name *(please circle)*

Saphris (asenapine)

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 request for a continuation of therapy? Y N
   [If no, then skip to question 3]
2. Do patient's progress notes or other supporting documentation note a response to therapy? Y N
   [No further questions]
3. Is the patient 18 years of age or older? Y N
   [If yes, skip to question 8]
4. Is the patient between 10 years and 18 years of age? Y N
   [If no, then no further questions]

5. Does the patient have a diagnosis of bipolar disorder? Y N
   [If no, then no further questions]

6. Has the patient had a trial and failure of at least two preferred atypical antipsychotics (i.e., risperidone, aripiprazole) with a minimum 30 day treatment period? Y N
   [If no, then no further questions]

7. Is the patient capable of following strict administration instructions including sublingual administration and no food or drink for ten minutes after administration? Y N
   [No further questions]

8. Does the patient have a diagnosis of a schizophrenia verified by supporting documentation or diagnosis codes? Y N
   [If no, skip to question 10]

9. Has the patient had a trial and failure of two preferred atypical antipsychotics with a minimum 30 day treatment period for each agent? Y N
   [No further questions]

10. Does the patient have a diagnosis of a Bipolar I Disorder verified by supporting documentation or diagnosis codes? Y N
    [If no, then no further questions]

11. Has the patient had a trial and failure or is intolerant to at least two of the following: A)Lithium, B) Valproic Acid, C) Combination of mood stabilizer and one preferred atypical antipsychotic, D) Combination of two or more mood stabilizers? Y N
    [If no, then no further questions]

12. Is the patient capable of following strict administration instructions including sublingual administration and no food or drink for ten minutes after administration? 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