Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

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

Drug Name *(circle drug)*

Xermelo (telotristat ethyl)

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. Does the patient have a diagnosis of carcinoid syndrome diarrhea with metastatic neuroendocrine tumors? Y N

   [If no, no further questions.]

2. Is the patient 18 years of age or older? Y N

   [If no, no further questions.]

3. Does the provider agree to assess the patient for severe constipation and abdominal pain and discontinue the medication if either develops? Y N

   [If no, no further questions.]

4. Is the request for continuation of therapy? Y N

   [If yes, skip to question 7.]

5. Has the patient had a trial and inadequate response to the maximum (or highest tolerated) dose of somatostatin analog (SSA) therapy (inadequate response is at least four or more bowel movements daily) for at least three consecutive months? Y N

   [If no, no further questions.]

6. Will Xermelo be used in combination with SSA therapy? Y N

   [No further questions]

7. Has the patient experienced a reduction from baseline in amount of average daily bowel movements per day? 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**