aetna™

Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at https://www.aetnabetterhealth.com/Illinois-medicaid

Increlex

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information		
Medication request is NOT for an FDA approved, or compendia supported diagnosis (circle one): ☐Yes ☐No	ICD-10 Code:	Diagnosis:
What medication(s) have been tried and failed for diagnosis?		
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No
Directions for Use:	Strength:	Dosage Form:
	Quantity: / Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information			
Does member have evidence of epiphyseal closure OR active OR suspected neoplasia?	☐ Yes	☐ No	
Is there a diagnosis of GH gene deletion with development of neutralizing antibodies to GH?	☐ Yes	☐ No	☐ N/A
Is there a diagnosis of severe, primary IGF-1 deficiency?	☐ Yes	☐ No	☐ N/A

Please check that apply:	☐ Height standard deviation score ≤ -3	☐ Basal IGF-1 standard deviation score ≤ -3	☐ Normal or high GH levels (> 10ng/mL on standard GH stimulation tests)

Is there evidence of secondary forms of IGF-1 deficiency (for example, GH deficiency, malnutrition, hypothyroidism or chronic treatment with pharmacologic doses of corticosteroids)?	☐ Yes	☐ No

☐ Renewal Requests ONLY:					
Did member have at least a doubling of pre-treatment growth velocity?	☐ Yes	☐ No	Did member have a growth velocity of ≥2.5 cm/yr?	☐ Yes	☐ No

Provider confirms ALL the following:	☐ Documentation of growth charts	☐ Epiphyses are open	☐ Member has no active or suspected neoplasia	☐ Member is not on concurrent GH therapy

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.