08/26/2015

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Acamprosate (IL88)

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 Illinois Medicaid at **1-844-242-0908**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Acamprosate (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (specify drug)
Acamprosate Calcium

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. Has this plan authorized this medicine in the past for this patient (e.g. previous authorization is on file under this plan)? Y N

   [If no, skip to question 3]

2. Did the patient have a documented clinical response to treatment? Y N

   [If yes, skip to question 7]

   [If no, then no further questions.]

3. Does the patient have a diagnosis of alcohol use disorder? Y N

   [If no, then no further questions.]

4. Is the patient, or will the patient be, abstinent from alcohol at treatment initiation? Y N

   [If no, then no further questions.]

5. Does the patient have severe renal impairment (creatinine clearance less than or equal to 30 mL per min)? Y N

   [If yes, then no further questions]

6. Has the patient experienced an inadequate response, intolerance or contraindication to naltrexone or disulfiram? Y N

   [If no, then no further questions]

7. Is patient enrolled in and compliant with substance abuse treatment program or psychosocial support plan? Y N

Comments:

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I affirm that the information given on this form is true and accurate as of this date.

____

Prescriber (Or Authorized) Signature **Date**