11/11/2015

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Topical NASIDs (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 Topical NASIDs (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Flector Patch (diclofenac epolamine patch)
Pennsaid (diclofenac sodium solution)
Voltaren Gel (diclofenac sodium gel)
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. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Is the patient responding to medication? Y N

   [No further questions.]

3. Does the patient have a history of OR is at high risk for adverse GI effects associated with oral NSAID use? If yes, please indicate all that apply to patient: Y N

_____

Note: The risk factors that correlate strongly to adverse GI effects of oral NSAID use are History of GERD, GI bleed, or ulcer \ Chronic oral corticosteroid use \ Current anticoagulant or antiplatelet use \ Age 65 or older

[If no, then skip to question 5.]

4. Has the patient had a trial and failure of celecoxib? Y N

[If yes, then skip to question 7.]

5. Does the patient have a high risk for other adverse effects associated with oral NSAID use (i.e., CHF, renal failure, concomitant use of lithium)? If yes, please indicate all that apply to patient: Y N

[If yes, then skip to question 7.]

6. Has the patient had a failure on TWO formulary NSAIDs? If yes, please list names of medications tried: Y N

[If no, then no further questions.]

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

[If no, then no further questions.]

8. Is this request for Voltaren gel AND does the patient have the diagnosis of OA (osteoarthritis) of the knee or hand? Y N

[If yes, then no further questions.]

9. Is this request for Pennsaid AND does the patient have the diagnosis of OA (osteoarthritis) of the knee? Y N

[If yes, then no further questions.]

10. Is this request for Flector patch for the treatment of acute pain? 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