Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Quantity Limit Exceptions (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 Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Quantity Limit Exceptions (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name

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 at the same dosage and quantity (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Has the patient had a response to treatment? Y N

   Note: Pharmacy claim history will be reviewed to verify compliance.

   [No further questions.]

3. Is this request for quantities that Exceed FDA Maximum Y N

Dose? (Refer to formulary for quantity limits.)

[If no, then skip to question 9.]

4. Did the patient have an inadequate response to the same medication at a lower dosage? Y N

   Please provide details:

   _____

5. Was medication non-adherence ruled out as a reason for the inadequate response? Y N

6. Is the patient tolerating the medication at a lower dosage? Y N

7. Is the requested quantity and dosing supported in medical-accepted compendia? Y N

   [If yes, then no further questions.]`

8. Has a peer-reviewed journal article demonstrating the safety and efficacy of the requested dose for the indication been submitted with this request? Y N

   [No further questions.]

9. Is this request for quantities of a lower strength that do not Exceed FDA Maximum Dose (e.g., two 30mg tablets/day in place of one 60mg tablet/day)? (Refer to formulary for quantity limits.) Y N

   [Note: Dose Optimization, use of a higher strength to allow a patient to take fewer doses to achieve the same total daily dose.]

   [If no, then skip to question 14.]

10. Is the dosing due to inadequate response to the optimized dose? Y N

    If yes, please provide reason:

    _____

    [If yes, then no further questions.]

11. Is the dosing due to patient inability to tolerate total daily dose in one administration? Y N

    [If yes, then no further questions.]

12. Is the dosing based on inability to swallow optimal dose? Y N

    [If yes, then no further questions.]

13. Is there a manufacturer shortage on the optimized strength? Y N

    [No further questions.]

14. Is this request for quantities for a medication that does not have Established FDA Maximum Dose? (Refer to formulary for quantity limits.) Y N

    [If no, then no further questions.]

15. Did the patient have an inadequate response to the same medication at a lower dosage? Y N

    Please provide details:

    _____

    [If no, then no further questions.]

16. Is the patient tolerating the medication at a lower dosage? Y N

    [If no, then no further questions.]

17. Is the requested dose considered medically necessary? Y N

    Please provide details:

    _____

Comments:

_____

_____

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

_____

Prescriber (Or Authorized) Signature Date