Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

CNS Stimulants (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 CNS Stimulants (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 (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 7.]

2. Is this a renewal request for Vyvanse for diagnosis of Binge eating disorder (BED)? Y N

   [If no, then skip to question 5.]

3. Does the patient continue to receive nutritional or psychological counseling? Y N

   [If no, then no further questions.]

4. Has there been a decrease in the number of binge days per week? Y N

   [If yes, then skip to question 6.]

   [If no, then no further questions.]

5. Did the patient have a documented clinical response to treatment? [If no, then no further questions] Y N

6. Is this a request for additional quantity since the last prior authorization approval? Y N

   If yes, please provide reason for additional quantity (e.g. change in dose, dosing frequency or higher dose):
   _____

   [No further questions.]

7. Is this request for Vyvanse for diagnosis of Binge eating disorder (BED)? Y N

   [If no, then go to question 14.]

8. Is the patient 18 to 55 years of age? Y N

   [If no, then no further questions.]

9. Does the diagnosis of Binge eating disorder (BED) meet DSM-5 criteria AND is being prescribed by, or in consultation with a psychiatrist? Y N

   [If no, then no further questions]

10. Is the patient's BMI (body mass index) greater than 25 kilograms per square meter? Y N

    If yes, please provide current BMI:_____

    [If no, then no further questions]

11. Is the patient receiving nutritional counseling or psychotherapy? Y N

    [If no, then no further questions]

12. Has the patient had an inadequate response or intolerance to at least TWO formulary medications (e.g., SSRIs, topiramate, or zonisamide.)? Y N

If yes, please list medications tried:

_____

[If no, then no further questions]

13. Does the patient have any of the following: A) recent history of substance abuse; B) use of MAOI (monoamine oxidase inhibitors) in past 14 days, C) history of cardiac disease (arrhythmia, cardiac structural abnormalities, CAD), D) concurrently taking other stimulants? Y N

    [If no, then skip to question 27.]

    [If yes, then no further questions.]

14. Is the patient taking another stimulant medication with the requested drug that is not a long-acting or short-acting formulation of the same drug? Y N

    [If yes, then no further questions.]

15. Is the requested dose within FDA recommended maximum daily dosage? Y N

    [If no, then no further questions]

16. Is this request for a preferred formulary stimulant agent? (Refer to formulary for a list of formulary agents)? Y N

    [If yes, then skip to question 19.]

17. Has the patient had a documented adverse reaction or contraindication to all preferred agents that does not also exist for the requested non-preferred drug? Y N

    If yes, please document agents tried and adverse reaction or contraindication: _____

    [If yes, then skip to question 19.]

18. Has the patient failed to respond to at least THREE formulary stimulants from both of the stimulant subclasses (e.g., amphetamine/dextroamphetamine AND methylphenidate/dexmethylphenidate)? Y N

    [Note: Requests for a non-preferred, EXTENDED RELEASE product require failure of extended release formulations of the preferred agents. Requests for a non-preferred, IMMEDIATE RELEASE product require failure of the immediate release

formulations of the preferred agents.]

If yes, please document names of drugs tried:

_____

[If no, then no further questions]

19. Is the patient less than 6 years of age? Y N

[If no, then skip to question 21.]

20. Does the patient continue to have ADHD/ADD symptoms despite participating in evidence-based behavior therapy (parent or teacher administered)? Y N

[If yes, then skip to question 27.]

[If no, then no further questions.]

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

[If no, then skip to question 26.]

22. Does the patient have diagnosis of idiopathic hypersomnia, narcolepsy, fatigue related to cancer or MS (multiple sclerosis)? Y N

[If yes, then skip to question 27.]

23. Does the patient have diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) OR Attention Deficit Disorder (ADD) and the symptoms meet the DSM5 (Diagnostic and Statistical Manual of Mental disorders) criteria? Y N

[If no, then no further questions.]

24. Is the diagnosis based on a comprehensive evaluation by an appropriate specialist and includes an evidence-based rating scale such as the Connors or Adult Self-Report Scale-V1.1 (ASRS-V1.1)? Y N

[If no, then no further questions.]

25. Has the provider ruled out other conditions (such as depression, anxiety, or substance use, including a urine drug screen for patients with a history of substance use disorder) OR they are being appropriately treated? Y N

[If yes, then skip to question 27.]

[If no, then no further questions.]

26. Does the patient have diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) OR Attention Deficit Disorder (ADD) or narcolepsy? Y N

27. Is this request for quantity limit exception? (Refer to formulary for covered quantity.) Y N

    [If no, then no further questions.]

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

    [If yes, then no further questions.]

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

    [If yes, then no further questions.]

30. Can the prescribed total daily dose be achieved with a lower quantity of a higher strength that does not exceed the quantity limit (e.g. one 60mg tablet/day in place of two 30 mg tablets/day)? Y N

    If no, please provide reason:

    _____

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

Comments:

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

Prescriber (Or Authorized) Signature Date