Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Compounded Drug Products (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 Compounded Drug Products (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. Is this request for a topical compound or a topical compound kit (e.g. cream, gel, lotion, ointment)? Y N

   [If yes, then no further questions.]

2. Is this request for nasal administration of nebulized anti-infectives for treatment of sinusitis? Y N

   [If yes, then no further questions.]

3. Is this request for a hormone therapy compound for menopause OR for androgen decline due to aging, (e.g., testosterone, estrogen, progestin, bioidentical hormone)? Y N

[If yes, then no further questions.]

4. Are each of the active ingredients in the compound FDA-approved drugs? Y N

   [Note: Examples of products that typically do not get FDA approval include bulk ingredients, dietary supplements, vitamin and mineral products, botanical or herbal products, amino acid products, enzyme supplements.]

   [If no, then no further questions.]

5. Are each of the active ingredients in the compound FDA-approved for the indication for which the compound is being prescribed? Y N

   [If no, then no further questions.]

6. Is the compound route of administration the same as the FDA-approved route of administration (ROA) for each active ingredient? Y N

   [Note: Examples of ROAs include mucosal, oral, parenteral (by injection), inhalation, topical/dermal]

   [If no, then no further questions.]

7. Is this request for formulary antibiotic or anti-infective for injectable use? Y N

   [If yes, then no further questions.]

8. Is there a current supply shortage of the commercially manufactured product? Y N

   [If yes, then no further questions.]

9. Does the patient have a medical need for a dosage form or dosage strength that is not available commercially or manufactured? Y N

   [If yes, then no further questions.]

10. Is this request for 17-HP (17-alpha hydroxyprogesterone caproate) for the prevention of preterm birth in women who are pregnant with a singleton pregnancy and have history of a prior spontaneous preterm birth? Y N

    Please provide reason for compounded 17-HP over Makena:

    _____

    [If yes, then no further questions.]

11. Has the patient had an intolerance or contraindication to the commercially manufactured product (e.g., allergen, adverse effects to inactive ingredients)? Y N

[Note: submission of an FDA MedWatch form consistent with DAW1 guidelines will be required.]

[If yes, then no further questions.]

12. Has the commercial product been discontinued by the pharmaceutical manufacturer for reasons other than lack of safety or effectiveness? 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