Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Direct Renin Inhibitors (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 Direct Renin Inhibitors (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Tekamlo (aliskiren/amlodipine) Tekturna (aliskiren)

Tekturna HCT (aliskiren/hydrochlorothiazide)

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. Does the patient have a diagnosis of Hypertension (HTN)? Y N

   [If no, then no further questions]

2. Has the patient experienced an inadequate treatment response, intolerance, or contraindication to 2 formulary alternatives, an Angiotensin Receptor Blocker (ARB) or an ACE inhibitor? Y N

   [If no, then no further questions]

3. Will the requested medication be used in combination with an ACE inhibitor or an ARB? Y N

[If yes, then no further questions]

4. Is the patient 18 years of age or older? 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