Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

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

Drug Name *(please circle)*

Movantik (naloxegol)

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 Aetna Better Health authorized Movantik (naloxegol) 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 Movantik and still taking opioid narcotics? Y N

   [No further questions]

3. Does the patient have Opioid-Induced Constipation (OIC) due to chronic non-cancer pain? Y N

[If no, then no further questions.]

4. Has the patient been taking opioids for at least 4 weeks? Y N

   [If no, then no further questions.]

5. Has the patient experienced an inadequate treatment response or intolerance to THREE formulary laxatives (e.g., lactulose, polyethylene glycol 3350, senna, bisacodyl, docusate sodium, magnesium hydroxide, magnesium citrate)? Y N

   [If no, then no further questions.]

6. 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