Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Testosterone (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 Testosterone (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 Aetna Better Health 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 3.]

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

   [No further questions.]

3. Is the requested drug being prescribed by, or in consultation with, an oncologist for the palliative treatment of inoperable breast cancer in a woman? Y N

   [If yes, then skip to question 18.]

4. Does the patient have the diagnosis of Delayed Puberty? Y N

   [If no, then skip to question 7.]

5. Is the requested drug being prescribed by, or in consultation with, a pediatric endocrinologist or urologist who has evaluated the patient and indicates that there are significant psychological reasons for use? Y N

   [If no, then no further questions.]

6. Is the patient 14 years of age or older? Y N

   [If yes, then skip to question 18.]

   [If no, then no further questions.] Y N

7. Is this request for hypogonadism in a male with consistent symptoms?

   [If no, then skip to question 12.] Y N

8. Does the patient have any of the following: A) Prostate cancer, B) Male breast cancer?

   [If yes, then no further questions.] Y N

9. Does the patient have a diagnosis of one of the following: A) Bilateral orchiectomy, B) Genetic disorder due to hypogonadism (e.g., Klinefelter's syndrome), C) Panhypopituitarism?

   [If yes, then skip to question 18.] Y N

10. Has the patient had two pretreatment serum total testosterone levels confirmed on two separate mornings with results below normal range (less than 280 ng/dL or less than the reference range for the laboratory)?

    [If yes, then skip to question 18.] Y N

11. Has the patient had one pretreatment FREE or bioavailable testosterone level with results below normal range (less than 5ng/dL or less than reference range for the laboratory)?

    [If yes, then skip to question 18.] Y N

    [If no, then no further questions.]

12. Is the requested drug for female to male Transsexualism? Y N

    [If no, then no further questions.]

13. Does the patient have the diagnosis of gender dysphoria as defined by the current version of Diagnostic and Statistical Manual of Mental Disorders (DSM V)? Y N

    [If no, then no further questions.]

14. Has the patient had psychosocial assessment done or had a period of psychotherapy of a duration specified by a mental health professional after initial evaluation (at least 6 months)? Y N

    [If no, then no further questions.]

15. Are significant medical or mental health concerns present? Y N

    [If no, then skip to question 17.]

16. Are they reasonably well controlled? Y N

    [If no, then no further questions.]

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

    [If no, then no further questions.]

18. Is the request for a brand name product? Y N

    Note: Brand name products are all non-formulary.

    [If no, then no further questions.] Y N

19. Did the patient experience an intolerable side effect or treatment failure with generic formulations made by 2 different manufacturers?

    [If no, then no further questions.] Y N

20. Was a MedWatch Form 3500 completed and submitted with this request?

    (Note: MedWatch form can be obtained from http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf) 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