Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

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

Drug Name *(please circle)*

Zoladex (goserelin)

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 this plan authorized Zoladex in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 5.]

2. Does the patient have breast or prostate cancer? Y N

   [If no, skip to question 4.]

3. Has the patient received Zoladex for less than 2 years? Y N

   [No further questions.]

4. Is Zoladex prescribed to treat dysfunctional uterine bleeding? Y N

   [No further questions.]

5. Is the patient at least 18 years old? Y N

   [If no, no further questions.]

6. Does the patient have a diagnosis of prostate cancer? Y N

   [If no, skip to question 8.]

7. Is Zoladex prescribed by or in consultation with an oncologist or urologist? Y N

   [No further questions.]

8. Is this request for the 3.6mg dose of Zoladex? Y N

   [If no, no further questions.]

9. Does the patient have a diagnosis of breast cancer? Y N

   [If no, skip to question 11.]

10. Is Zoladex prescribed by or in consultation with an oncologist? Y N

    [No further questions.]

11. Is Zoladex prescribed by or in consultation with a gynecologist or obstetrician? Y N

    [If no, no further questions.]

12. Does the patient have a diagnosis of endometriosis? Y N

    [If no, skip to question 14.]

13. Has the patient had a trial and failure of at least one formulary hormonal cycle control agent (such as ethinyl estradiol plus levonorgestrel, ethinyl estradiol plus drospirenone, or ethinyl estradiol plus norgestimate), medroxyprogesterone, or Danazol? Y N

    Please indicate which medication(s) patient tried:

    _____

    [If yes, skip to question 16.]

    [If no, no further questions.]

14. Is Zoladex requested for use as an endometrial thinning agent for Y N

dysfunctional uterine bleeding?

[If no, then no further questions.]

15. Does the patient have planned endometrial ablation or hysterectomy within the next 4-8 weeks? Y N

    If yes, please document date surgery is scheduled:_____

    [No further questions]

16. Has the patient already received 6 months of treatment with Zoladex? 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