

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Pulmonary Arterial Hypertension Agents (IL88)

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 Medicaid at 1-844-242-0908. Please contact Aetna Better Health Illinois Medicaid at 1-866-212-2851 with questions regarding the Prior Authorization process.

When conditions are met, we will authorize the coverage of Pulmonary Arterial Hypertension Agents (IL88). Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (specify drug)

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: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed by or in consultation with a pulmonologist or cardiologist with experience in treating pulmonary hypertension? If yes, please document specialist name and specialty: Y N

[If no, no further questions.]

2. Does the patient have a diagnosis of pulmonary arterial hypertension (PAH)? Y N

[If no, skip to question 6.]

3. Is the request for generic sildenafil? Y N

[If no, skip to question 5.]

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|--|---|---|
| 4. Is the patient at least 17 years of age? | Y | N |
| [No further questions.] | | |
| 5. Is the request for Adempas, Opsumit, or Veletri? | Y | N |
| [If yes, skip to question 8.] | | |
| [If no, no further questions.] | | |
| 6. Does the patient have a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH)? | Y | N |
| [If no, no further questions.] | | |
| 7. Is the request for Adempas? | Y | N |
| [If no, no further questions.] | | |
| 8. Is the patient at least 18 years of age? | 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