09/25/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)
Antipsychotics 8 to 18 Years of Age (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 Antipsychotics 8 to 18 Years of Age (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 patient between 8 and 18 years of age? Y N

   [If no, no further questions.]

2. Is this a renewal authorization for this medicine? Y N

   (e.g., previous authorization is on file)
   [If no, then skip to question 4.]

3. Is the patient responding to treatment? Y N

   [No further questions.]

4. Is the request being prescribed by or in consultation with a psychiatrist or neurologist? Y N

   [If yes, then skip to question 9.]

5. Is the medication being prescribed for an appropriate indication/diagnosis for the medication based on FDA approval, nationally established/recognized guidelines, peer-reviewed medical literature or clinical studies? Y N

6. Is the age of the patient within FDA-approved age limits for the medication prescribed or based on nationally established/recognized guidelines, peer-reviewed medical literature or clinical studies? Y N

7. Is the dose being prescribed appropriate for age and indication based on FDA approval, nationally established/recognized guidelines, peer-reviewed medical literature or clinical studies? Y N

8. Has written, informed consent for the medication been obtained from the parent or guardian? Y N

9. Is the request for a formulary antipsychotic? Y N

   (e.g. chlorpromazine, clozapine, fluphenazine, haloperidol, loxapine, olanzapine, perphenazine, risperidone, quetiapine, thioridazine, thiothixene, ziprasidone)

   [If yes, then no further questions.]

10. Has the patient had a trial and failure of formulary antipsychotic agents? Please document medications and dosages tried, dates of trial and reason for failure: 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