09/25/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)
Antipsychotics for Children Less Than 8 (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 for Children Less Than 8 (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 under 8 years of age? Y N

   [If no, then 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

4. Is the requesting prescriber a psychiatrist or neurologist or is the prescriber supplying proof of a psychiatric consultation? Y N

5. Does the patient have one of the following diagnoses: Y N

   Organic Psychiatric Conditions \ Schizophrenic Disorders \ Affective Psychoses (bipolar disorders) \ Psychoses \ Autism Spectrum Disorders \ Tourette's \ Reactive Adjustment Disorders \ Other applicable behavioral diagnoses

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

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

   (e.g. risperidone)

   [If yes, then no further questions.]

8. 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