09/25/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)
Benicar, Diovan, Tekturna (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 Benicar, Diovan, Tekturna (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Benicar HCT Tablets (olmesartan-HCTZ)
Benicar Tablets (olmesartan)
Diovan Tablets (valsartan)
Tekturna HCT (aliskiren-hydrochlorothiazide)
Tekturna Tablets (aliskiren)
Valsartan-HCTZ Tablets

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 this request for Tekturna or Tekturna HCT? Y N

   [If yes, then skip to question 6.]

2. Does the patient meet the following? Y N

   For Diovan/ valsartan HCT, is 6 years of age or older \
   For Benicar/Benicar HCT, is 6 years of age or older and weighs at least 20kg

3. Is the prescriber a cardiologist? Y N

   [If yes, then no further questions.]

4. Has the patient had 2 fills of the following first-line agents in the last 90 days? Y N

   ACE inhibitors \ Losartan, losartan-HCTZ

   [If yes, then no further questions.]

5. Does the patient have a documented intolerance to an ACE inhibitor and losartan, or losartan-HCTZ? Y N

   [No further questions.]

6. Did the patient have a failure of, or contraindication to formulary ACE inhibitors, followed by trial and failure of formulary ARBs (losartan, Benicar, Diovan)? Please list medication tried and reason for treatment 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