09/25/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (MEDICAID)
Emend (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 Emend (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)

Aprepitant Emend (aprepitant)

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 prescriber an oncologist? Y N

   [If the answer to this question is yes, then no further questions required.]

2. Is this a request that has been previously approved? Y N

   [If the answer to this question is no, then skip to question 4.]

3. Is the patient responding to therapy? Y N

   [No further questions required.]

4. Is this request for prevention of postoperative nausea and vomiting? Y N

   [If the answer to this question is no, then no further questions required.]

5. Has the patient had a trial and failure of or intolerance to a preferred 5-HT3 antagonist (e.g., ondansetron, granisetron)? Y N

   [If the answer to this question is yes, then no further questions required.]

6. Does the patient have a contraindication to a preferred 5-HT3 antagonist? 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