08/26/2015

# Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Non-Calcium Based Phosphate Binders (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 **1-855-684-5250**.
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 Non-Calcium Based Phosphate Binders (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

## Drug Name (specify drug)

Fosrenol Chew Tab (lanthanum carbonate) Fosrenol Pow (lanthanum carbonate)
Velphoro (sucroferric oxyhydroxide) Other, Please specify
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: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for the treatment of hyperphosphatemia (elevated phosphate) due to ESRD (end stage renal disease)? Y N

   [If no, then no further questions]

2. Is the patient receiving dialysis? Y N

   [If no, then no further questions]

3. Is the patient 18 years of age or older? Y N

   [If no, then no further questions]

| | Y | N |
|---|---|---|
| 4. Has the patient experienced an inadequate treatment response to Renvela or Renagel (sevelamer) AND a calcium-based phosphate binder?<br><br>[If yes, then no further questions] | | |
| 5. Does the patient have a contraindication to Renvela or Renagel (sevelamer) AND calcium-based phosphate binders? Please specify contraindication if applicable: | 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