08/26/2015

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Acamprosate (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 Acamprosate (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)

Julbia (efinaconazole) Kerydin (tavaborole) Luzu (luliconazole)
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 patient 18 years of age or older? Y N

   [If no, then no further questions]

2. Is this request for Luzu? Y N

   [If no, skip to question 8]

3. Has this plan authorized this medicine in the past for this patient (e.g. previous authorization is on file under this plan)? Y N

   [If no, skip to question 5]

4. Did the patient have a documented clinical response to Y N

treatment?

[No further questions]

5. Is the requested drug being prescribed for the topical treatment of tinea pedis, tinea cruris, and tinea corporis? Y N

   [If no, then no further questions]

6. Has the patient experienced an inadequate treatment response or contraindication to terbinafine cream? Y N

   [If no, then no further questions]

7. Has the patient experienced an inadequate treatment response on at least 1 other formulary topical antifungal agents (i.e. clotrimazole, ciclopirox, econazole, ketoconazole, miconazole, etc.) OR contraindication to all formulary agents? Y N

   [No further questions]

8. Is the requested drug being prescribed for treatment of onychomycosis of the toenails for a patient with at least one of the following conditions? Y N

   Diabetes \ HIV \ Immunosuppression (i.e. receiving chemotherapy, taking long term oral corticosteroids, taking anti-rejection medications) \ Peripheral vascular disease \ Pain caused by the onychomycosis

   [If no, then no further questions]

9. Has the patient experienced an inadequate treatment response to at least 2 formulary antifungal agents indicated for onychomycosis (i.e. ciclopirox, griseofulvin, itraconazole and terbinafine tablets)? Please list formulary medications trialed: Y N

   _____

10. Does the patient have a contraindication to all formulary Y N

antifungal agents indicated for onychomycosis (i.e. ciclopirox, griseofulvin, itraconazole and terbinafine tablets)? Please specify contraindication, if applicable:

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date