9/01/2013

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS

Oxycontin (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 at **1-855-684-5250**.
Please contact Aetna Better Health Illinois at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Oxycontin (IL88).

Drug Name (select from list of drugs shown)

Oxycontin (oxycodone) oxycodone CR

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 request for more than 90 tablets of Oxycontin per 30 days? PLEASE DOCUMENT OXYCONTIN STRENGTH(S), DIRECTIONS FOR USE, AND QUANTITY REQUESTED: Y N

2. Is Oxycontin prescribed for pain associated with cancer/malignancy? DOCUMENT DIAGNOSIS HERE: Y N

   ____

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

3. Is this a renewal request for Oxycontin? Y N

   [If the answer to this question is no, then skip to question 5.]

4. Is patient responding to Oxycontin? Y N

   [No further questions are required.]

5. Has the patient tried and failed at least two formulary long-acting agents (e.g., fentanyl patches, morphine ER tablets and methadone)? IF YES, PLEASE DOCUMENT AGENTS AND DATES USED AND REASON FOR TREATMENT FAILURE: ______________________________________ Y N

   ____

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

6. Does the patient have a contraindication to formulary long-acting analgesics? IF YES, PLEASE DOCUMENT SPECIFIC AGENTS AND CONTRAINDICATIONS: Y N

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Comments:

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

____

Prescriber (Or Authorized) Signature **Date**