

Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

HIV Inappropriate-Interaction (Medicaid)

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.

When conditions are met, we will authorize the coverage of HIV Inappropriate-Interaction (Medicaid).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name _____

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. According to pharmacy claims records, the requested medication interacts with an existing antiretroviral drug the patient may be taking. Y N
 Will the interacting drug be discontinued?

Comments: _____

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

Prescriber (Or Authorized) Signature _____

Date _____