

Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Pulmozyme (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 Pulmozyme (Medicaid).

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

Drug Name *(please circle)*

Pulmozyme (dornase alfa)

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. Does the patient have a diagnosis of cystic fibrosis?

Y N

[If no, then no further questions.]

2. Is the patient 5 years of age or older?

Y N

Note: Pulmozyme could be reviewed in patients under 5 years of age who may experience daily cough or to those with FEV1 below the normal range.

Comments:

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

Prescriber (Or Authorized) Signature

Date