Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Insulin Pens (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 **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Insulin Pens (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. Does the patient have a diagnosis of Type I or Type II Diabetes Mellitus? Y N
2. Is there documentation to support that the patient meets one of the following: A) a school-aged child requiring multiple daily injections, B) visual impairment, C) physical disability or dexterity problems and unable to draw up syringe, D) environmental factors which prevent use of vial formulation? Y N
3. Is this request for a non-formulary agent (Refer to formulary for preferred agents)? Y N

[If no, then no further questions.]

4. Is there documentation to support an inadequate response, intolerance, or contraindication to 2 formulary insulins within the same class (i.e., rapid, regular, or basal)? 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