Pharmacy Prior Authorization

AETNA BETTER HEALTH LOUISIANA (MEDICAID)

Growth Hormones (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 Louisiana at **1-844-699-2889**.
When conditions are met, we will authorize the coverage of Growth Hormones (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name

Specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____
Member ID: _____
Member Group No.: _____
Member DOB: _____
Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis:_____ ICD Code:_____

Circle the appropriate answer for each question.

1. Does the member have a diagnosis appropriate for the requested drug? Y N

   [If no, then no further questions.]

2. Is the requested drug prescribed by or in consultation with an endocrinologist, gastroenterologist or nephrologist? Y N

   [If no, then no further questions.]

3. Has the member had a treatment failure with an adequate trial (3 months) of at least one preferred product? Y N

   [If yes, then skip to question 7.]

4. Has the member had an intolerable side effect to at least one preferred Y N

product?

[If yes, then skip to question 7.]

5. Has the member had a documented contraindication(s) to all of the preferred products that are appropriate to use for the condition being treated? Y N

   [If yes, then skip to question 7.]

6. Is there a preferred product that is appropriate to use for the condition being treated? Y N

   [If yes, then no further questions.]

7. Does the prescriber attest to the following: A) The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements, B) All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended, C) The member has no inappropriate concomitant drug therapies or disease states, D) There is confirmation of open growth plates in members older than 12 years of age? Y N

   [If no, then no further questions.]

8. Is the member currently using the requested drug? Y N

   [If no, then no further questions.]

9. Is there evidence of a positive response to therapy as indicated by improvement in signs, symptoms, and lab results compared to baseline? 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