Pharmacy Prior Authorization

AETNA BETTER HEALTH LOUISIANA (MEDICAID)

Hemophilia Agents (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 Hemophilia Agents (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. Is there a preferred alternative that is the exact same chemical entity, formulation, strength, etc.? Y N

   [If yes, no further questions.]

2. Has the member had a treatment failure with at least one preferred product? Y N

   [If yes, skip to question 7.]

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

   [If yes, skip to question 7.]

4. Does the member have documented contraindications to the preferred Y N

products that are appropriate to use for the condition being treated?

[If yes, skip to question 7.]

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

[If no, skip to question 7.]

6. Is the member currently using the requested medication? Y N

[If no, no further questions.]

7. Does the provider attest to all of the following? Y N

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 requests.

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 recipient has no inappropriate concomitant drug therapies or disease states.

Comments:

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

Prescriber (Or Authorized) Signature Date