Pharmacy Prior Authorization

AETNA BETTER HEALTH LOUISIANA (MEDICAID)

Multiple Sclerosis 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 Multiple Sclerosis 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. Does the member have a diagnosis of multiple sclerosis (ICD-10 code G35)? Y N

   [If no, then no further questions.]

2. Is the request for a preferred medication? Note: Gilenya, Copaxone, Avonex, Rebif, Rebif Rebidose, and Betaseron are preferred agents. Y N

   [If yes, skip to question 12.]

3. Is this request for a non-preferred medication that does not have a chemically equivalent preferred product that is the exact same entity, formulation, strength, etc.? Y N

   [If yes, skip to question 6.]

4. Is this request for a non-preferred medication that does have a chemically Y N

equivalent preferred product that is the exact same entity, formulation, strength, etc.?

[If no, then no further questions.]

5. Is there documentation in the recipient's medical record stating that the recipient is unable to use the chemically equivalent preferred product for reasons such as a contraindication or clinically significant adverse effect(s) to the inactive ingredient(s)? Y N

   [If no, then no further questions.]

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

   [If no, skip to question 8.]

7. Is current use of the requested medication established through use of medication samples, coupons or discount cards? Y N

   [If no, skip to question 12.]

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

   [If yes, skip to question 12.]

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

   [If yes, skip to question 12.]

10. Does the member have a documented contraindication(s) to the preferred products that are appropriate to use for the condition being treated? Document medication(s), condition, and contraindications: Y N

    _____

    [If yes, skip to question 12.]

11. Is there a preferred product appropriate for the condition being treated? Y N

    [If yes, then no further questions.]

12. Has 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? Y N

    [If no, then no further questions.]

13. Have all laboratory testing and clinical monitoring recommended in the prescribing information been completed as of the date of the request and will be repeated as recommended? Y N

[If no, then no further questions.]

14. Does the member have any inappropriate concomitant drug therapies or disease states? Y N

    [If yes, then no further questions.]

15. Is the requested medication being prescribed by or in consultation with a neurologist? Y N

    [If no, then no further questions.]

16. Has this plan authorized the requested medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

    [If yes, skip to question 18.]

17. Is this request for Lemtrada? Y N

    [No further questions.]

18. Is the member responding positively to therapy? Y N

    [If no, then no further questions.]

19. Is this request for Ampyra? Y N

    [If no, skip to question 21.]

20. Has the patient's walking improved with Ampyra therapy? Y N

    [No further questions.]

21. Is this request for Lemtrada? Y N

    [If no, then no further questions.]

22. Has it been at least 12 months since completion of the most recent treatment course? Y N

    [If no, then no further questions.]

23. Is the duration of treatment for the renewal 3 consecutive days? 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