02/18/2014

Prior Authorization Form

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Insulin Pens (IL88)

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 Medicaid] at **1-855-684-5250.**
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Insulin Pens (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Humalog KwikPen (insulin Lispro)
Humulin 70/30 Pen (Insulin R and NPH)
Humulin N Pen (Isophane Insulin)
Lantus Solostar (Insulin Glargine)
Levemir FlexPen (Insulin Detemir)
Novolog FlexPen (Insulin Aspart)

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: ___________________________
Physician Phone: ___________________________
Physician Fax: ___________________________
Physician Address: ___________________________
City, State, Zip: ___________________________

Diagnosis:______________________________ **ICD Code:**______________________________

Please circle the appropriate answer for each question.

1. Is the patient a school-aged child requiring multiple daily injections of insulin (as supported by medical records)? Y N

   [If yes, then no further questions.]

2. Does patient have an uncorrectable visual disturbance (e.g., macular degeneration, retinopathy, vision uncorrectable by prescription glasses) OR physical disability or dexterity problems due to stroke, peripheral neuropathy, trauma, or other physical condition that prevents the patient from effectively self-administering insulin using insulin vials and syringes (as supported by medical records)? Y N

3. Does the patient have a caregiver who can administer insulin to patient using insulin vials and syringes? 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**