04/18/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Pulmonary Arterial Hypertension Agents (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 Pulmonary Arterial Hypertension Agents (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)

Adcirca (tadalafil)	Adempas (riociguat)	Flolan (epoprostenol)
Letairis (ambrisentan)	Opsumit (macitentan)	Remodulin (treprostinil injection)
Sildenafil	Tracleer (bosentan)	Tyvaso (treprostinil inhalation solution)
Veletri (epoprostenol)	Ventavis (iloprost)	

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 requested drug being prescribed by or in consultation with a pulmonologist or cardiologist with experience in treating pulmonary hypertension? If yes, please document specialist name and specialty: ____ Y N

   [If no, no further questions.]

2. Does the patient have a diagnosis of pulmonary arterial hypertension (PAH)? Y N

[If no, skip to question 6.]

3. Is the request for generic sildenafil? Y N

[If no, skip to question 5.]

4. Is the patient at least 17 years of age? Y N

[No further questions.]

5. Is the request for Adempas, Opsumit, or Veletri? Y N

[If yes, skip to question 8.]

[If no, no further questions.]

6. Does the patient have a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH)? Y N

[If no, no further questions.]

7. Is the request for Adempas? Y N

[If no, no further questions.]

8. Is the patient at least 18 years of age? Y N

Comments:

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

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Prescriber (Or Authorized) Signature **Date**