Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

DPP-4 Inhibitors (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 New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of DPP-4 Inhibitors (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 _____

Patient information

Patient name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient 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 the patient CURRENTLY taking metformin? Y N

   [If yes, then skip to question 4.]

2. Did the patient have a previous inadequate response or adverse effect to metformin? Y N

   Please explain reason for metformin failure:

   _____

   [If yes, then skip to question 4.]

3. Does the patient have any of the following contraindications to metformin: A) Renal dysfunction (serum creatinine greater than 1.4mg per dL for females or greater than 1.5mg per dL for males), B) Metabolic acidosis, C) Diabetic Y N

ketoacidosis?

Please list contraindication(s):

_____

[If no, then no further questions.]

4. Is the patient 18 years of age or older? Y N

   [If no, then no further questions.]

5. Is this request for a formulary preferred agent? (Review formulary status for preferred drugs) Y N

   [If yes, then no further questions.]

6. Has the patient had a trial and failure of TWO formulary preferred DPP4 Inhibitors? (Review formulary status for preferred drugs) Y N

   Please list medications tried and reason for medication failure:

   _____

Comments:

_____

_____

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

_____

Prescriber (Or Authorized) Signature **Date**