Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

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

   [If no, skip to question 3.]

2. Is there supporting documentation showing clinical improvement or stabilization of the disease state? Y N

   [No further questions.]

3. Is the prescribed dose, frequency of use, and duration of therapy within the Food and Drug Administration (FDA)-approved range for the indication or is supported by compendia/peer-reviewed literature? Y N

[If no, no further questions.]

4. Is the request for experimental/investigational use or for a clinical trial? Y N

   [If yes, no further questions.]

5. Please provide the condition the parenteral immunoglobulin is prescribed for.

   List condition: _____

Comments:

_____

_____

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

_____

Prescriber (Or Authorized) Signature **Date**