07/26/2016

Prior Authorization

AETNA BETTER HEALTH OF NEW JERSEY (MEDICAID)

GLP-1 Agonists (NJ88)

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 of New Jersey at **1-855-296-0323**.
Please contact Aetna Better Health of New Jersey at **1-855-232-3596** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of GLP-1 Agonists (NJ88).
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)

Bydureon (exenatide extended release)
Byetta (exenatide)
Tanzeum (albiglutide)
Trulicity (dulaglutide)
Victoza (liraglutide)
Other, Please specify

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: _____

Please 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 ketoacidosis? Y N

   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? (refer to the formulary for a list of preferred agents) Y N

   [If yes, then no further questions.]

6. Has the patient had a trial and failure of ALL formulary preferred GLP-1 Agonists? (refer to formulary for a list of preferred agents) 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