Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Sylatron (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 Sylatron (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Sylatron (peginterferon alfa-2b)

Other, 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. Does the patient have a diagnosis of malignant melanoma? Y N

   [If no, then no further questions.]

2. Is Sylatron being prescribed by, or in consultation with a hematologist/oncologist? Y N

   [If no, then no further questions.]

3. Is the patient at least 18 years old? Y N

   [If no, then no further questions.]

4. Has the patient received Sylatron therapy for greater than or equal to 5 years? 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**