08/11/2014

Prior Authorization

Aetna Better Health of New Jersey

Non-Formulary Medications (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 Non-Formulary Medications. 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)

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: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health of New Jersey authorized this medicine in the past for this patient (e.g. previous authorization is on file under Aetna Better Health of New Jersey)? Y N

   [If the answer to this question is no, then skip to question 3.]

2. Is the patient responding to therapy? Y N

   [No further questions required.]

3. Is this a request ONLY for a quantity limit exception for this medication (e.g., medication is on the formulary without prior authorization or step therapy)? If yes, please document drug strength, quantity requested, directions for use, and reason for exceeding the quantity limit (e.g., Y N

indicate if a lower dose has been tried):
_____

[If the answer to this question is yes, then no further questions required.]

4. Has the patient tried at least 2 formulary agents in the same drug class? If yes, please list the medications tried and reason for treatment failure: _____ Y N
_____

If the answer to this question is yes, then no further questions required.]

5. Does the patient have a contraindication, such as drug allergy or serious drug interaction to formulary alternatives? If yes, please list the medications and contraindications here: _____ 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