Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Abuse Deterrent Products (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 Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Abuse Deterrent Products (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name

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 18 years of age or older? Y N
2. Has the patient had a trial and failure of non-opioid analgesics? Y N

   [Note: Documentation must be submitted.]
3. Has the patient had a trial and failure to immediate release opioids (tolerance and adequacy of the medication must be addressed)? Y N

   [Note: Documentation must be submitted.]
4. Has documentation been submitted with the justification of the need for the management of pain Y N

severe enough to require daily, around the clock, long-term opioid treatment (not indicated for as needed analgesia)?

5. Has the patient had a trial and failure of preferred agent Embeda? 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