Aetna Better Health® of Florida (MEDICAID)

Oral Oncology Agents

(Maximum Approval = One Year)
Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number - -

Prescriber Fax Number - -

Provider Specialty: _____

Medication Request: **New** **Continuation** **Ht**: _____ in _____ cm **Wt**: _____ lb _____ kg **BSA:** _____

1. **Medication Requested:**

Medication	Strength	Directions	# of Cycles	Quantity/Month

2. **Diagnosis**

☐ Breast Cancer ☐ Renal Cancer ☐ Prostate Cancer ☐ Lung Cancer ☐ Ovarian Cancer

☐ Leukemia ☐ Other Diagnosis: _____

3. **Previous Medication Trials**

Medication	Strength	Directions	Start/End Dates	Maximum Dose (Per Day)

4. **List all other medications the patient is taking concurrently with the antineoplastic:**

Medication	Strength	Directions	# of Cycles

PRESCRIBER'S SIGNATURE **DATE**

REQUIRED FOR REVIEW: Copies of medical records (i.e. diagnostic evaluations and recent chart notes), and the most recent copies of related labs

The provider must retain copies of all documentation for five years.

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Fax completed prior authorization request form to **Aetna Better Health of Florida at 855-799-2554** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

For Plan Use Only

DATE: _____ **NOTIFIED:** _____

APPROVED: _____ **START DATE:** _____ **EXPIRATION DATE:** _____

DENIED: _____ **REASON:** _____