Prior Authorization Form

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Zoladex (IL88)

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 Illinois Medicaid at **1-855-684-5250.**
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Zoladex (IL88).
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)

Zoladex (goserelin)

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. Does the patient have a diagnosis of prostate cancer? Y N

   [If no, skip to question 4.]

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

   [If no, no further questions.]

3. Is Zoladex prescribed by or in consultation with an oncologist or urologist? Y N

[No further questions.]

4. Is this request for the 3.6mg dose of Zoladex? Y N

[If no, no further questions.]

5. Does the patient have a diagnosis of breast cancer? Y N

[If no, skip to question 8.]

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

[If no, no further questions.]

7. Is Zoladex prescribed by or in consultation with an oncologist? Y N

[No further questions.]

8. Does the patient have a diagnosis of endometriosis? Y N

[If no, skip to question 14.]

9. Is the request for retreatment of endometriosis? Y N

[If yes, skip to question 11.]

10. Has the patient had a trial and failure of at least one formulary medication unless contraindicated (i.e., medroxyprogesterone or other hormonal cycle control agents [e.g., Portia, Ocella])? Please indicate which formulary medications patient failed (if patient has a contraindication, please indicate drug and contraindication): Y N

[If yes, skip to question 16.]

[If no, no further questions.]

11. Will Zoladex be used in combination with norethindrone acetate 5 mg daily? Y N

[If no, no further questions.]

12. Does the patient have bone density values (DEXA or BMD) within normal limits? Please provide date of Bone Density exam and result: Y N

    [If no, no further questions.]

13. Has the patient completed an original 6-month course of treatment followed by an additional 6 months of treatment (1 year total)? Y N

    [If yes, no further questions.]

    [If no, skip to question 16.]

14. Is Zoladex requested for use as an endometrial thinning agent for dysfunctional uterine bleeding? Y N

    [If no, no further questions.]

15. Has the patient had a trial and failure of at least one formulary medication unless contraindicated (i.e., estrogen, medroxyprogesterone, and other hormonal control agents [e.g., Portia, Ocella])? Please indicate which formulary medications patient failed (if patient has a contraindication, please indicate drug and contraindication): Y N

    [If no, no further questions.]

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

    [If no, no further questions.]

17. Is Zoladex prescribed by or in consultation with a gynecologist or obstetrician? 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**