aetna™

Aetna Better Health®

**Fax completed prior authorization request form to 844-802-1412** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.** Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/Illinois-medicaid

# Pharmacy Prior Authorization Request Form

**Do not copy for future use. Forms are updated frequently.**
**REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.**

| **Member Information** | | | |
|---|---|---|---|
| Member Name (first & last): | Date of Birth: | Gender: ☐ ☐ | Height: |
| Member ID: | City: | State: | Weight: |
| **Prescribing Provider Information** | | | |
| Provider Name (first & last): | Specialty: | NPI#: | DEA#: |
| Office Address: | City: | State: | Zip Code: |
| Office Contact: | Office Phone: | | Office Fax: |
| **Dispensing Pharmacy Information** | | | |
| Pharmacy Name: | Pharmacy Phone: | | Pharmacy Fax: |
| **Requested Medication Information** | | | |
| Medication Name: | Strength: | | Dosage Form: |
| Directions for Use: | Quantity: | Refills: | Duration of Therapy/Use: |

☐ Check if requesting **brand** only (Must include copy of MedWatch form)

**Turn-Around Time For Review**

☐ Standard - (24 hours) ☐ **Urgent** - by waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. Signature:__________________

**Clinical Information**

**1. What is the diagnosis? Please specify below.**

☐ Medication request is NOT for an FDA-approved, or compendia-supported diagnosis

**ICD-10 Code:** ______________________________ **Diagnosis Description:** ______________________________

**2.** ☐ **New** request

☐ Continuation of therapy request

If yes, Please specify (circle one) how this medication was started:

Previous Prior Authorization, Paid under Another Insurance, Recent Hospital Discharge or Other______________________

**3.** ☐ Yes ☐ No Are there any contraindications to formulary medications?

If yes, please specify: ___________________________

Yes ☐ No Is this a request for an increase or decrease in dose or quantity of a previously approved medication?

**4. What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**

Important note: Samples provided by the prescriber are not accepted as continuation of therapy or as an adequate trial and failure. For Brand name requests, generic formulation from 2 different manufacturers is required along with MedWatch form.

| Medication Name, Strength, Frequency | Dates started and stopped or Approximate Duration | Reason therapy was discontinued |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**5. Are there any supporting labs or test results? Please specify below.**

| Date | Test | Value |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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**6. Is there any additional information the prescribing provider feels is important to this review? Please specify below or submit medical records.**

For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

**7.** ☐ Yes ☐ No Is request for a patient that is on an insulin pump? Make and Model: ______________________________
Note: Omnipod is preferred.

| **Signature affirms that information given on this form is true and accurate and reflects office notes** | |
|---|---|
| Prescribing Provider's Signature: | Date: |

**Please note**:

Some medications may require completion of a drug-specific request form. Please refer to plan website at www.aetnabetterhealth.com/Illinois-medicaid for drug-specific criteria forms.

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Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.