



# Request for Medicare Prescription Drug Coverage Determination

Page 1 of 2 (You must complete both pages.)

Urgent (24 hrs.)     Standard (72 hrs.)

Aetna Better Health® Premier Plan  
MMAI (Medicare-Medicaid Plan)  
Part D Coverage Determinations  
Pharmacy Department  
4750 S 44th PL STE 150  
Phoenix, AZ 85040-4015  
FAX: 1-855-365-8109  
PHONE: 1-866-600-2139 (TTY: 711)  
24 Hours, 7 days a week  
[AetnaBetterHealth.com/Illinois](http://AetnaBetterHealth.com/Illinois)

Patient information		Prescriber information	
Patient name		Today's date	Physician specialty
Patient insurance ID number		Physician name	NPI/DEA number
Patient address, city, state, ZIP		Physician address, city, state, ZIP	
Patient home telephone number		M.D. office telephone number	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient date of birth	M.D. office fax number	
Diagnosis and medical information			
Medication requested		Strength and route of administration	Frequency
New prescription OR date therapy initiated		Quantity	Day supply
Expected length of therapy			
Diagnosis (Please include all office notes supporting diagnosis.)			
Please check all boxes that apply:			
<b>1. Check the box that best describes medication administration location:</b> <input type="checkbox"/> Patient's home or assisted living facilities <input type="checkbox"/> Office administered (pharmacy supplies drug) <input type="checkbox"/> Long Term Care Facilities (LTC)/Skilled Nursing Facilities (SNF) <input type="checkbox"/> Office administered (office supplies drug) /J CODE: _____ <input type="checkbox"/> Ambulatory Infusion Center (infusion center supplies drug) <input type="checkbox"/> Other (explain): _____ <input type="checkbox"/> Ambulatory Infusion Center (retail/outpatient pharmacy supplies drug)			
<b>2. <input type="checkbox"/> Patient is stable on current drug(s) and/or current quantity, and therapy change would likely result in an adverse clinical outcome.</b>			
<b>3. <input type="checkbox"/> All covered Part D drugs on any tier of the plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would likely have adverse effects for the enrollee.</b>			
<b>4. The American Geriatric Society recommends avoiding high risk medications (HRM) in the elderly as a safety concern. To ensure safe use of potentially high risk medications (HRM) in the elderly population, prescriber must acknowledge that medication benefits outweigh potential risks in the elderly.</b> <i>Note: Members under 65 years of age are not subject to the prior authorization requirements.</i> <input type="checkbox"/> The requested medication is medically necessary and the clinical benefits outweigh the risks for this specific patient.			
<b>5. <input type="checkbox"/> Yes    <input type="checkbox"/> No    Does patient have a diagnosis of cancer?</b>			
<b>6. <input type="checkbox"/> Yes    <input type="checkbox"/> No    Is the patient on dialysis?</b>			
<b>7. Complete this section if the requested drug is an immunosuppressant being used to prevent transplant rejection:</b> <input type="checkbox"/> What was the date of the patient's transplant (mm/dd/yy)? ____/____/____			

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Aetna Better Health® Premier Plan MMAI is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees. ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-866-600-2139 (TTY: 711), 24 hours a day, 7 days a week. The call is free.

ATENCIÓN: Si habla español, tiene a su disposición servicios de idiomas gratuitos. Llame al 1-866-600-2139 (TTY: 711), las 24 horas del día, los 7 días de la semana. Esta llamada es gratuita.



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Please check all boxes that apply (continued):

8. Complete this section if the requested drug is being used in a nebulizer (inhalation solutions i.e albuterol, ipratropium, Tobi etc.) or an infusion pump (insulin vials, morphine infusion, chemotherapy for liver cancer etc.):

- The patient resides in one of the following long-term care (LTC) facilities:
  - A nursing home that is dually-certified as both a Medicare SNF and a Medicaid nursing facility (NF)
  - A Medicaid-only NF that primarily furnishes skilled care, a non-participating nursing home (i.e. neither Medicare nor Medicaid) that provides primarily skilled care, an institution which has a distinct part SNF and which also primarily furnishes skilled care
- The patient resides in his or her own home **OR**
- The patient resides in an assisted living facility **OR**
- The patient resides at other locations not listed here; provide the name, phone number and address:

\_\_\_\_\_

9.  Yes  No Does patient require higher dosage (quantity limit exception)?

▶ If yes, indicate quantity requested: \_\_\_\_\_ per 30 days OR quantity \_\_\_\_\_ per day

- The number of doses available under the dose restriction for the prescription drug has been ineffective in the treatment of the enrollee's disease or medical condition.
- The number of doses available under the dose restriction for the prescription drug, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

10.  Please list all medications the patient has tried specific to the diagnosis and specify below.

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

11.  Other supporting information

\*NOTE: All exception requests require prescriber supporting statements. Additionally, requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Please attach supporting information, as necessary, for your request.

\_\_\_\_\_

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

Prescriber signature	Date
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