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