aetna™

Aetna Better Health®

Fax completed prior authorization request form to 877-270-3298 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/maryland/providers/pharmacy

HIV: Duplicative Use, Inappropriate Interaction, and Unboosted Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	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				
Request is for (specify medication name):				
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No		ICD-10 Code:	Diagnosis:	
Are there any contraindications to formulary medications? (if yes, please specify)	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request
What medication(s) have been tried and failed for diagnosis? (please specify):				

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information					
Does the requested medication represent a therapeutic duplication with an existing antiretroviral drug the patient may be taking?	☐ Yes	☐ No	If yes, will the prescriber evaluate the patient's regimen and discontinue duplicative drug(s)?	☐ Yes	☐ No
Does the requested medication interact with or is inappropriate with existing antiretroviral drug(s) the patient may be taking?	☐ Yes	☐ No	If yes, will the prescriber evaluate the patient's regimen and discontinue interacting or inappropriate drug combination(s)?	☐ Yes	☐ No
Has the member filled a prescription for a boosting agent?	☐ Yes	☐ No	If yes, does the member's current regimen include a boosting agent? Note: Guidelines and product labeling recommend concurrent use of a boosting agent, such as ritonavir or cobicistat, or combination drugs that include boosting agents to improve virologic response to treatment.	☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

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 866-827-2710 to check the status of a request.