

Statement of Medical Necessity for Brand-Name Drug Override

Fax completed prior authorization request form to
888-601-8461 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 AetnaBetterHealth.com/Oklahoma.

Please make sure that the member's ID Number is on every page faxed.

THIS SECTION IS TO BE COMPLETED BY THE PHARMACY:

Member Name:	Member ID Number:
Member Date of Birth:	Dispensing Pharmacy Phone Number:
Dispensing Pharmacy Name:	Dispensing Pharmacy Fax Number:
Dispensing Pharmacy NPI:	Requested Drug Name & Strength:
Requested Drug NDC Number:	Requested Drug Monthly Quantity:
Requested Drug Dosing Regimen:	Requested Drug Fill Date:
Prescriber Name:	Prescriber NPI:
Prescriber Phone Number:	Prescriber Fax Number:

THIS SECTION MUST BE COMPLETED AND SIGNED BY THE PRESCRIBER:

Patient needs the requested brand-name drug rather than its FDA approved generic equivalent because:

Patient experienced an adverse event while using the generic medication.

The generic medication was not effective for the patient.

Other (Please explain): _____

Please answer the following questions about what happened when the patient took the generic medication:

1. Generic medication taken (Give labeled strength, mfr/labeler, lot #, & exp. date, if known):

2. Dose, frequency, & route used:

3. Date(s) patient took the generic medication (give from/to or best estimate):

4. Diagnosis for use:

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Member ID
Number (REQUIRED):

5. Description of adverse event or problem:

6. How long after beginning use of drug did the event occur?

7. Outcomes attributed to adverse event caused by generic medication:

- Life-threatening Hospitalization – initial or prolonged Disability
- Intervention was required to prevent permanent impairment/damage
- Other: _____

8. Event abated after use stopped or dose reduced? Yes No Doesn't apply

If yes, how long after stopping or reducing dose of drug did event abate?

9. Event reappeared after reintroduction? Yes No Doesn't apply

10. Concomitant medical products & therapy dates: _____

11. Relevant Tests/Laboratory Data, Including Dates: _____

12. Other Relevant History, Including Preexisting Medical Conditions (e.g., allergies, race, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.):

13. Patient's drug/excipient allergies:

14. Patient's Weight: _____

15. Patient's Height: _____

****Request may require additional supporting documentation.****

Prescriber Signature: _____ **Date:** _____

(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)