Medical Exception/Prior Authorization/Precertification* Request for Prescription Medications

Non-Specialty drug Prior Authorization Requests Fax: 1-877-269-9916
Specialty drug Prior Authorization Requests Fax: 1-888-267-3277
OR, Submit your request online at: www.availity.com
Visit www.aetna.com/formulary to access our Pharmacy Clinical Policy Bulletins.

For FASTEST service, call 1-855-240-0535, Monday-Friday, 8 a.m. to 6 p.m. Central Time

Patient Information		Prescriber Information	
Patient Name		Today's Date	
Patient Insurance ID Number		Physician Name	
Patient Address, City, State, ZIP		Physician Address	
Home Telephone		M.D. Office Telephone Number	
Gender ☐ **Male** ☐ **Female**	Patient Date of Birth	M.D. Office Fax Number	

Diagnosis and Medical Information

Medication		Strength	Frequency
Expected Length of Therapy	Quantity	Day Supply	If this is a continuation of therapy, how long has the patient been on the medication?

Is this medication being used to treat a chronic or long-term condition for which this prescription medication may be necessary for the life of the patient? ☐ **Yes** ☐ **No**

PLEASE CHECK ALL BOXES THAT APPLY:

Do you want a drug specific prior authorization criteria form faxed to your office? ☐ Yes ☐ No **(If yes, no further questions are required).**

☐ What condition is the drug being prescribed for? ICD code _____
Diagnosis _____

☐ Does the patient have a diagnosis of cancer? ☐ Yes ☐ No

☐ **STEP THERAPY** may be required. Please list all medications the patient has tried specific to the diagnosis and specify below:
Therapeutic failure, including length of therapy for each drug: _____
Drugs (s) contraindicated: _____
Adverse even (e.g., toxicity, allergy) for each drug: _____

☐ Is the request for a patient with one or more chronic conditions (e.g., psychiatric condition, diabetes) who is stable on the current drug(s) and who might be at high risk for a significant adverse event with a medication change? If so, specify anticipated significant adverse event:
_____

☐ Has the condition been confirmed by diagnostic testing? If so, please provide diagnostic test and date:
_____

☐ Please provide any pertinent lab testing values for the members diagnosis : _____
_____

☐ Does the patient have a clinical condition for which other alternatives are not recommended based on published guidelines or clinical literature? If so, please provide documentation: _____

☐ Does the patient require a specific dosage form (e.g., suspension, solution, injection)? If so, please provide dosage form:
_____

☐ Are additional risk factors (e.g., GI risk, cardiovascular risk, age) present? If so, please provide risk factors: _____
_____

☐ Other: Please provide additional relevant information: _____
_____

REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION.
PLEASE COMPLETE CORRESPONDING SECTION ON BACK PAGE FOR THE SPECIFIC DRUG/CLASS LISTED BELOW.
Antiemetic (5-HT3) Agents/Erectile Dysfunction Agents/Stimulants/ Provigil, Nuvigil/Testosterones
FOR ANY DRUG/CLASS NOT LISTED ON THE BACK PAGE, PLEASE ATTACH ADDITIONAL INFORMATION, BUT CANNOT EXCEED TWO PAGES
PRESCRIPTION BENEFIT PLAN MAY REQUEST ADDITIONAL INFORMATION OR CLARIFICATION, IF NEEDED, TO EVALUATE REQUESTS

☐ **Urgent Request: I certify that applying a standard review timeframe might seriously jeopardize the life or health of the patient.**

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.

Prescriber Signature	**Date**

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PLEASE COMPLETE CORRESPONDING SECTION FOR THESE SPECIFIC DRUGS/CLASSES LISTED BELOW AND CIRCLE THE APPROPRIATE ANSWER OR SUPPLY RESPONSE.

☐ **ERECTILE DYSFUNCTION: CIALIS, LEVITRA, VIAGRA, ALPROSTADIL:**

Does the patient require nitrate therapy on a regular OR on an intermittent basis, or is the patient currently taking another ED medication? ☐ Yes ☐ No

If a diagnosis of erectile dysfunction, is it due to neurogenic etiology, vasculogenic etiology, psychogenic etiology or mixed etiology? ☐ Yes ☐ No

Is it being used for symptomatic Benign Prostatic Hyperplasia (BPH)? ☐ Yes ☐ No

☐ **ANTIEMETIC (5-HT3) AGENTS:**

Is the patient receiving moderate to highly emetogenic chemotherapy? Monthly frequency _____ ☐ Yes ☐ No

Is the patient receiving radiation therapy? Monthly frequency _____ ☐ Yes ☐ No

If the patient has a diagnosis of Hyperemesis Gravidarum, has the patient experienced an inadequate treatment response to two of the following medications?

Vitamin B6, doxylamine, promethazine (Phenergan), trimethobenzamide (Tigan) or metoclopramide (Reglan)? ☐ Yes ☐ No

☐ **TOPICAL TESTOSTERONES REPLACEMENT (lab requirements):**

For testosterone replacement therapy, has the member been confirmed by one of the following ☐ Yes ☐ No

1. two total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available) which were drawn in the morning between 7:00 a.m. and 10:00 a.m. on two different days, **OR**
2. persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) which were drawn in the morning between 7:00 a.m. and 10:00 a.m. on two different days

☐ **PROVIGIL/NUVIGIL:**

If the patient has a diagnosis of Obstructive Sleep Apnea, is the patient currently using a continuous positive airway pressure (CPAP) machine or another device? ☐ Yes ☐ No

☐ **ADHD STIMULANTS AND NON-STIMULANTS:**

Is this a renewal of existing therapy? ☐ Yes ☐ No

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If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: **711**,
Fax: **859-425-3379** (CA HMO customers: **860-262-7705**), **CRCoordinator@aetna.com**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019**, **800-537-7697** (TDD).

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