aetna™

Aetna Better Health®

Fax completed prior authorization request form to 855-799-2554 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/florida/providers/provider-pharmacy

Tepezza

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				
What medication(s) has member tried and failed for this diagnosis? Please specify:				
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): ☐Yes ☐No	Diagnosis:	ICD-10 Code:		
Are there any contraindications to formulary medications? If yes, please specify:			☐ Yes	☐ No
Directions for Use:	Strength:	Dosage Form:		
	Quantity:	Day Supply:	Duration of Therapy/Use:	

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – 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						
Member has one of the following diagnosis:	☐ Moderate to severe Graves' orbitopathy (ophthalmopathy)	☐ Thyroid-associated ophthalmopathy (thyroid eye disease (TED))				
Was there T/F with glucocorticoids? (cumulative dose <1000mg methylprednisolone OR equivalent)	☐ Yes	☐ No	Are glucocorticoids C/I or cannot be tolerated?	☐ Yes	☐ No	
Was member on a high dose (> 1000mg methylprednisolone OR equivalent) steroid therapy in the past 4 weeks?				☐ Yes	☐ No	
Is there documentation of baseline testing for all of the following:	☐ Proptosis ☐ Clinical Activity Score of greater than or equal to 4 ☐ Diplopia ☐ Graves' ophthalmopathy-specific quality-of-live (GO-QOL) questionnaire					
Does member require immediate surgical ophthalmological intervention?	☐ Yes	☐ No	Is there a plan for corrective surgery/irradiation?	☐ Yes	☐ No	
Is there documentation the member is:	☐ Euthyroid ☐ Mildly hypo/hyper-thyroid with free thyroxine (FT4) ☐ Free triiodothyronine (FT3) levels less than 50% above or below normal limits					
Will provider monitor for elevated Blood Glucose and symptoms of hyperglycemia?	☐ Yes	☐ No	Will a female of reproductive potential be using effective contraception prior to starting therapy, during treatment, and for 6 months following last dose of Tepezza?	☐ Yes	☐ No	☐ N/A

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 to check the status of a request.
Medicaid: 800-441-5501
Florida Healthy Kids: 844-528-5815