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 https://www.aetnabetterhealth.com/Illinois-medicaid

Antidepressants Non-Preferred
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					
Selective Serotonin Reuptake Inhibitors (SSRIs):	☐ Trintellix	☐ Viibryd	☐ Pexeva	☐ Fluoxetine WEEKLY	☐ Fluoxetine TABLETS
	☐ Fluvoxamine ER	☐ Paroxetine ER	☐ Paroxetine mesylate capsule		
Serotonin/Norepinephrine Reuptake Inhibitors (SNRIs):	☐ Fetzima	☐ Venlafaxine SR TABS	☐ Pristiq	☐ Khedezla	☐ desvenlafaxine
☐ Other, please specify:					

Are there any contraindications to formulary medications? (If yes, please specify):	☐ Yes	☐ No	☐ New request

☐ **Continuation of therapy request:**		
Has member responded to therapy with this medication?	☐ Yes	☐ No
Is member new to Plan AND/OR was using samples of non-preferred antidepressant AND currently stable? (circle one): ☐ Yes ☐ No	Was non-preferred antidepressant started during recent hospitalization? (circle one): ☐ Yes ☐ No	
Medication request is NOT for FDA-approved, or compendia-supported diagnosis (circle one): Yes ☐ No ☐	ICD-10 Diagnosis Code:	Diagnosis:

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 Criteria for All New Starts			
Is there formulary preferred agent available in different formulation that is of same ingredient? (Pexeva, Aplenzin, Forfivo XL, fluvoxamine ER, paroxetine mesylate, fluoxetine weekly)	☐ Yes	☐ No	
Was there documented trial and failure with that formulary agent?	☐ Yes	☐ No	☐ N/A

Additional Criteria			
☐ **Major Depressive Disorder** ☐ **Seasonal Affective Disorder**			
Is there documented trial and failure OR intolerance to 3 formulary agents from at least 2 different classes of antidepressants for at least 4 weeks? (SSRI, SNRI, bupropion, or mirtazapine)?	☐ Yes	☐ No	☐ N/A
Are ONE of these trials with preferred formulary agent from same class? (SSRI or SNRI)?	☐ Yes	☐ No	
Is there documented trial AND failure OR intolerance with 2 formulary agents PLUS an antidepressant augmentation regimen for at least 4 weeks? (SSRI or SNRI PLUS one of the following: Bupropion, Lithium, atypical antipsychotic, Buspirone OR Liothyronine)	☐ Yes	☐ No	☐ N/A
Are ONE of these trials with preferred formulary agent from same class (SSRI or SNRI)?	☐ Yes	☐ No	
☐ **Obsessive-Compulsive Disorder**			
Is there documented trial AND failure OR intolerance to 3 formulary agents (SSRIs, clomipramine) for at least 4 weeks?		☐ Yes	☐ No
☐ **Panic Disorder** ☐ **Generalized Anxiety Disorder**			
Is there documented trial AND failure OR intolerance to 3 formulary agents from at least 2 different classes of antidepressants for at least 4 weeks? (SSRIs or SNRIs)		☐ Yes	☐ No
☐ **Hot Flashes Associated with Menopause**			
Is there documented trial AND failure OR intolerance to 3 formulary agents from at least 2 different classes of antidepressants for at least 4 weeks? (SSRIs or SNRIs)		☐ Yes	☐ No
Is member preference to avoid hormonal therapy?		☐ Yes	☐ No
☐ **Premenstrual Dysphoric Disorder**			
Is there documented trial AND failure OR intolerance to 3 formulary SSRIs for 4 weeks?		☐ 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 866-329-4701 to check the status of a request.