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

Atypical Antipsychotics
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						
☐ Clozapine ODT	☐ Rexulti	☐ paliperidone ER	☐ quetiapine ER	☐ Saphris	☐ Latuda	☐ Fanapt
☐ Vraylar	☐ Secuado	☐ Other, please specify:				

Are there any contraindications to medications? (If yes, please specify):	☐ Yes	☐ No	☐ New request
☐ Continuation of therapy requests require documentation of following (check that apply):	☐ Improvement in target symptoms	☐ Screen for movement disorders	
	☐ Treatment plan containing rationale for continued use or plan for D/C		
	☐ Member weight	☐ Metabolic screen	

Is member new to Plan AND/OR using samples for a NON-PREFERRED antipsychotic? (circle one): ☐ Yes ☐ No

Is request for more than ONE antipsychotic due to needed 60-day cross titration? (circle one): Yes ☐ No ☐	Did member start on NON-PREFERRED antipsychotic during recent HOSPITALIZATION? (circle one): ☐ Yes ☐ No

Medication request is NOT for an FDA-approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No

Diagnosis ICD-10 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 Information
☐ **Children 6-17 Years of Age**

Was blood glucose OR hemoglobin A1C completed at baseline AND then yearly?	☐ Yes	☐ No	Was cholesterol testing OR LDL-C completed at baseline AND then yearly?	☐ Yes	☐ No
Was weight completed at baseline AND then yearly?	☐ Yes	☐ No	Was screening for movement disorders associated with antipsychotic therapy completed?	☐ Yes	☐ No
NEW STARTS ONLY:					
Are residual symptoms continuing despite use non-pharmacologic therapies such as behavioral, cognitive AND family based therapies?				☐ Yes	☐ No

Additional Criteria Based on Indication

☐ **Bipolar Disorder**	☐ **Schizophrenia**	☐ **Psychomotor Agitation Associated with Autism Spectrum Disorder**	☐ **Chronic Tic Disorder**	☐ **Tourette's Syndrome**

Is requested antipsychotic a PREFERRED agent?	☐ Yes	☐ No	If no, was there inadequate response OR intolerable side effect to TWO PREFERRED agents?	☐ Yes	☐ No

☐ **Major Depressive Disorder**

Was there inadequate response OR intolerable side effect to THREE different medication regimens for depression for at least 4 weeks?	☐ Yes	☐ No	Did medication regimen include antidepressant monotherapy?	☐ Yes	☐ No
Did medication regimen include antidepressant augmentation with SSRI OR SNRI + bupropion OR Lithium OR buspirone OR liothyronine?				☐ Yes	☐ No
Is requested antipsychotic PREFERRED agent?	☐ Yes	☐ No	Was there inadequate response OR intolerable side effect to TWO PREFERRED atypical antipsychotics?	☐ Yes	☐ No

Clinical Information – NON-PREFERRED AGENTS

☐ **Adults 18 Years of Age or Older**

Was blood glucose OR hemoglobin A1c completed at baseline AND then yearly?	☐ Yes	☐ No	Was cholesterol testing OR LDL-C completed at baseline AND then yearly?	☐ Yes	☐ No
Was weight completed at baseline AND then yearly?	☐ Yes	☐ No	Was screening for movement disorders associated with antipsychotic therapy completed?	☐ Yes	☐ No

Additional Criteria Based on Indication

☐ **Bipolar Disorder**	☐ **Schizophrenia**

Was there inadequate response OR intolerable side effect to TWO PREFERRED atypical antipsychotics?			☐ Yes	☐ No

☐ **Major Depressive Disorder**

Was there inadequate response OR intolerable side effect to THREE different medication regimens for depression for at least FOUR weeks?	☐ Yes	☐ No	Did medication regimen include antidepressant monotherapy?	☐ Yes	☐ No
Did medication regimen include antidepressant augmentation with SSRI OR SNRI + bupropion OR Lithium OR buspirone OR liothyronine?	☐ Yes	☐ No	Was there inadequate response OR intolerable side effect to TWO PREFERRED atypical antipsychotics?	☐ Yes	☐ No

☐ **Children Age 5 and Under**

Are residual symptoms continuing despite use of NON-PHARMACOLOGIC THERAPIES such as behavioral, cognitive AND family based therapies?				☐ Yes	☐ No
Was baseline AND routine monitoring of weight AND BMI OR waist circumference completed?	☐ Yes	☐ No	Was baseline AND routine monitoring of BP, fasting glucose AND fasting lipid panel completed?	☐ Yes	☐ No
Was baseline and routine monitoring of tardive dyskinesia using AIMS or DISCUS completed?				☐ 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.