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 Antipsychotic Long-Acting Injectables
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:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ Urgent – Waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function; you are requesting an expedited decision. Signature: ______________________________

Requested Medication Information			
☐ Risperdal Consta	☐ Perseris	☐ Zyprexa Relprevv	☐ Other, please specify:

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

☐ New request	☐ Continuation of therapy (check that apply):	☐ Improvement in target symptoms	☐ Screen for tardive dyskinesia
		☐ Metabolic screening within last 60 days	

Was medication started during recent hospitalization? (circle one): Yes No	Is member stable (new to plan and/or using samples) on non-preferred antipsychotic therapy? Yes No

Was oral dose received per FDA approved labeling to confirm tolerability and efficacy? Yes No	ICD-10 Code:	Diagnosis:

What medication(s) were tried and failed for this diagnosis?	Are there any contraindications to formulary medications?	☐ Yes	☐ No
	(If yes, specify):		

Directions for Use:	Strength:	Dosage Form:	
	Quantity:	Day Supply:	Duration of Therapy/Use:

Clinical Information					
Has member had OR is at high risk for non-adherence to ORAL antipsychotic medications?	☐ Yes	☐ No	Will member receive concurrent ORAL antipsychotics after initial overlap period?	☐ Yes	☐ No

Provider agrees to support	☐ BP	☐ Weight, BMI	☐ Fasting	☐ Fasting	☐ Tardive Dyskinesia

baseline AND routine monitoring of ALL the following (check that apply):		OR waist circumference	Lipid Panel	Glucose	using AIMS or DISCUS

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:** ______________

<u>Please note: Incomplete forms or forms without the chart notes will be returned</u>

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.

Proprietary