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

Egrifta

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 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				
Medication request is NOT for FDA approved or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:	ICD-10 Code:		
Are there any contraindications to formulary medications? If yes, specify:		☐ Yes	☐ No	☐ New request
☐ Continuation of therapy ONLY:	Was there positive clinical response of HbA1c within normal range?	☐ Yes	☐ No	
	Was there positive clinical response of IGF-1 within normal range?	☐ Yes	☐ No	
	Was there a decrease in waist circumference?	☐ Yes	☐ No	

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:
What medication(s) has the member tried and failed for this diagnosis? Please specify below.			

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								
Is MALE waist circumference ≥95cm at start of therapy?	☐ Yes	☐ No	☐ N/A	Is FEMALE waist circumference ≥94cm at start of therapy?	☐ Yes	☐ No	☐ N/A	
Is member currently receiving anti-retroviral therapy?	☐ Yes	☐ No		Was there baseline evaluation within past 3 months of HgB A1C AND IGF?	☐ Yes	☐ No		
Will HgB A1C be monitored every 3-4 months?	☐ Yes	☐ No		Is member at risk for medical complications due to excess abdominal fat?	☐ Yes	☐ No		
Does member have active malignancy?	☐ Yes	☐ No		Does member have disruption of hypothalamic-pituitary gland axis OR head trauma?	☐ Yes	☐ No		

Is member a woman of childbearing age who is NOT pregnant AND using appropriate contraception?	☐ 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.