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

Emflaza

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 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	☐ New request				
☐ Continuation of therapy ONLY:	Has there been clinical benefit from therapy documented as improvement in baseline motor milestone scores?	☐ Yes	☐ No	Will Emflaza be given concurrently with live vaccinations?	☐ Yes	☐ No	
	Does member have active infection (including HBV)?	☐ Yes	☐ No	If member has history of HBV infection, will provider monitor for HBV reinfection?	☐ 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							
Did genetic testing demonstrate mutation in dystrophin gene?	☐ Yes	☐ No	Did muscle biopsy show total absence of dystrophin OR abnormal dystrophin?	☐ Yes	☐ No		
Is creatine kinase at least 10 times ULN?	☐ Yes	☐ No	Was there a trial of prednisone for at least 6 months?	☐ Yes	☐ No		
Was there unmanageable AND clinically significant weight gain / obesity OR psychiatric / behavioral issues (abnormal behavior, aggression, or irritability) as result of trial of prednisone?				☐ Yes	☐ No		

Baseline motor milestone score was completed by one of the following:	☐ 6-minute walk test (6MWT) ☐ North Star Ambulatory Assessment (NSAA) ☐ Motor Function Measure (MFM) ☐ Hammersmith Functional Motor Scale (HFMS)

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.