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

Idiopathic Pulmonary Fibrosis
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				
☐ Esbriet	☐ Ofev			
☐ Other, please specify:				
What medication(s) has member tried and failed for this diagnosis? Please specify:				
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request
Medication request is NOT for an FDA approved, or compendia supported diagnosis (circle one): ☐Yes ☐No	Diagnosis:		ICD-10 Code:	
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						
The diagnosis of idiopathic pulmonary fibrosis is confirmed by ONE of the following:		☐ High resolution computed tomography demonstrating usual interstitial pneumonia		☐ Surgical lung biopsy with usual interstitial pneumonia		
Is FVC ≥50% predicted?	☐ Yes	☐ No	Is Carbon Monoxide Diffusion Capacity ≥30%	☐ Yes	☐ No	
Were baseline LFTs completed?	☐ Yes	☐ No	Is member a current smoker?	☐ Yes	☐ No	
Have other known causes of interstitial lung disease been ruled out? (for example, domestic AND occupational environmental exposures, connective tissue disease OR drug toxicity)				☐ Yes	☐ No	
☐ Renewal Requests ONLY:						

Does member have a stable FVC?	☐ Yes	☐ No	Are LFTs being monitored?	☐ Yes	☐ No
Is member a current smoker?	☐ Yes	☐ No	Has member been compliant and adherent to treatment?	☐ 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.