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

Interferons

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			
☐ Alferon N	☐ Intron A	☐ Pegasys	☐ Actimmune
☐ Other, please specify:			

Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request
What medication(s) has member tried and failed for this diagnosis?				

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					
☐ **Chronic Hepatitis B**					
Current lab reports to support the following:	☐ Documentation ALT ≥2 times ULN	☐ Documentation of elevated Hepatitis B Virus DNA level	☐ Above 2,000 IU/mL Hepatitis B e-antigen negative		
	☐ Significant histologic disease	☐ Above 20,000 IU/mL Hepatitis B e-antigen positive			
Is there evidence of compensated Liver disease?				☐ Yes	☐ No
☐ **Renewal ONLY:**					
Is lab report supportive of Hepatitis B e-antigen POSITIVE?	☐ Yes	☐ No	Is lab report supportive of Hepatitis B e-antigen NEGATIVE?	☐ Yes	☐ No
☐ **Follicular Non-Hodgkin's Lymphoma (Stage III/IV)**					
Will requested medication be given in conjunction with anthracycline-containing combination chemotherapy?				☐ Yes	☐ No
☐ **Acquired Immune Deficiency Syndrome (AIDS)-Related Kaposi's Sarcoma**					

Confirm member age per above:			Confirm provider specialty per above:		
☐ **Hairy-Cell Leukemia**					
Did member have less than a complete response to cladribine or pentostatin?				☐ Yes	☐ No
Was there a relapse after <2 years of demonstrating a complete response to cladribine OR pentostatin?				☐ Yes	☐ No
☐ **Renewal ONLY:**					
Is there evidence of disease progression?				☐ Yes	☐ No
☐ **Chronic Granulomatous Disease**					
Confirm member age per above:			Confirm provider specialty per above:		
☐ **Renewal ONLY:**					
Is there evidence of disease progression?				☐ Yes	☐ No
☐ **Malignant Osteopetrosis**					
Confirm diagnosis per above:			Confirm provider specialty per above:		
☐ **Renewal ONLY:**					
Is there evidence of disease progression?				☐ Yes	☐ No
☐ **Condylomata acuminata - Genital or Venereal Warts**					
Is requested medication for intra-lesional use?	☐ Yes	☐ No	Are the lesions small and limited in number?	☐ Yes	☐ No
Did member have trial and failure with TOPICAL treatments (for example, imiquimod cream, podofilox)?				☐ Yes	☐ No
Was there trial and failure with a surgical technique (for example, cryotherapy, laser surgery, electrodessication, surgical excision)?				☐ Yes	☐ No
☐ **Renewal ONLY:**					
Was there at least 3 months between treatments, unless lesions grow, or new lesions appear?				☐ 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.