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

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

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 Immune Thrombocytopenia**				
There was insufficient response to the following:	☐ corticosteroids	☐ immunoglobulins	☐ splenectomy	☐ Thrombopoietin Receptor Agonists (Promacta, Nplate) or Rituxan

Was there trial and failure, or contraindication to Promacta tablet AND Nplate?	☐ Yes	☐ No	Is baseline platelet count <30 x 109/L?	☐ Yes	☐ No
Will provider monitor CBCs, AND platelet counts monthly, until stable platelet count (50 x 109/L) is achieved?				☐ Yes	☐ No
Will provider monitor LFTs such as ALT, AST and bilirubin monthly?	☐ Yes	☐ No	Will provider monitor BP every 2 weeks until establishment of stable dose, then monthly thereafter?	☐ Yes	☐ No
Will there be concomitant use with a strong CYP3A4 inducer (for example, phenobarbital, carbamazepine)?				☐ Yes	☐ No
☐ **Renewal Requests ONLY:**					

After 12 weeks, has platelet count increased to a level enough to avoid clinically important bleeding?	☐ Yes	☐ No	Is provider continuing to monitor CBCs, including neutrophils, BP, LFTs?	☐ 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.