Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

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All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/oklahoma

Universal Petition for Medication Authorization Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender: M ☐ F ☐	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 Name:	Strength:		Dosage Form:
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

Turn-Around Time For Review

☐ Standard - (24 hours) ☐ **Urgent** - by waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. Signature:_____

Clinical Information

1. What is the diagnosis? Please specify below.

☐ Medication request is NOT for an FDA-approved, or compendia-supported diagnosis

ICD-10 Code: _____ **Diagnosis Descript on:** _____

2. ☐ **New** request

☐ Continuation of therapy request

If yes, please specify (circle one below) how this medication was started:
Previous Prior Authorization, Paid under Another Insurance, Recent Hospital Discharge or Other_____

3. ☐ Yes ☐ No Are there any contraindications to PDL medications?
If yes, please specify: _____

☐ Yes ☐ No Is this a request for an increase or decrease in dose or quantity of a previously approved medication?

4. What medication(s) has the individual tried and failed for this diagnosis? Please specify below.
Important note: Samples provided by the prescriber are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Reason therapy was discontinued

5. Are there any supporting labs or test results? Please specify below.

Date	Test	Value

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Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below or submit medical records.

For example, explain the negative impact on medical condition, safety issue, reason PDL agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of PDL agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form. Please refer to plan website at www.aetnabetterhealth.com/oklahoma for drug-specific criteria forms.

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 844-365-4385 to check the status of a request.