

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

## **Opioids**

## **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	on																
Member Name (first & last):						Date of Birth:			Gender:					Height:			
Member ID:						City:			□ Male □ □ F ate:				emale Weight:				
Prescribing Provide	er Infori	mation															
Provider Name (first					Specia	alty:	NPI#						DEA#	#			
Office Address:					City:		State:						Zip C	ode:			
Office Contact:					Office	Phone	Phone			Office Fax:							
Dispensing Pharma	acy Info	rmation			L					1							
Pharmacy Name:	-				Pharm	acy Pho	one:			Pharn	nacy Fa	acy Fax:					
Requested Medica	tion Info	rmation								1							
Preferred Long-Ac		Morphine S	Sulfate E	R tablet	:S												
Non-Preferred Long-Acting Opioid:				Specify drug:													
Short-Acting Opioid	Spe	Specify drug:															
Are there any conti specify):	raindicat	tions to f	l ormu	lary medio	cations?	(if yes,	please	□ Y	es	□ No		New reque	st	☐ Con	tinuation ther		
Directions for Use:					Strength:						Dosage Form:						
						Quantity: Day Supply:					Duration of Therapy/Use:						
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one):  Yes No					Diagnosis: ICD-10 Code:												
What medication(s)		en tried a	and fa	ailed for th	is diagno	osis? Pl	ease spe	cify:									
Turn-Around Time	fau Davi																
☐ Standard – (24			rega	ent – If wai ain maximu ature:								arm li	fe, he	ealth, or a	bility to	)	
Clinical Information	n																
□ Long-Acting O	pioids																
The requested drug is being prescribe due to ONE of the following:			ed	□ Can	cer	Sickl Cell Disea			ninal dition		alliative nd of lif			Hospice		N/A	
Is request for non- preferred product?	Yes	No	to t	s there ina he formula	ary alter	native, r	morphine	sulfate				ΠY	es	□ No	□ N/	A	
The requested drug term treatment in a	_	-				evere er	nough to	require	daily,	, around	-the-clo	ock, lo	ng-	□ Yes	□ No	<b>5</b>	

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## 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.