

Fax completed prior authorization request form to 877-309-8077 or submit Electronic Prior Authorization through CoverMyMeds[®] or SureScripts.

Aetna Better Health®

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/pennsylvania/providers/pharmacy

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 Name (first & last): Member ID:					Date	of Birth:	Gender:				Height:		
								Male	lle 🛛 🗆 Fen		е		
					City:		State:						
Prescribing Provider	Information												
Provider Name (first & last):				Specialty: NPI#					EA#				
Office Address:				City:	City: State:				Zip C	Zip Code:			
Office Contact: Off					office Phone				Office Fax:				
Dispensing Pharmacy	y Information	1											
Pharmacy Name:				Pharmacy Phone:				Pharr	Pharmacy Fax:				
Requested Medicatio	on Informatio	n		1									
Preferred Long-	Buprene	orphine	ine 🗆 Fentanyl 🛛		Methadone		□ Morphine Sulfate		e 🛛 🗆 Tr		ramadol Extended		
Acting Opioid:	Patch		Patch				Extended-Release		Tablets	Tablets Relea		ts	
Non-Preferred Long-A	Acting Opicid	- Sno	cify drug:										
		. Sper	any unug.										
Short-Acting Opioid: Specify drug:													
Are there any contrain	ndications to	formula	ary medio	cations?	(if yes,	please	□ Yes	□ No		ew	□ Con	tinuatio	
specify):			-							request of		thera	
Directions for Use:					Strength:				Dosage Form:				
					Outon	gun							
					Quan	tity:	Day Su	oply:	Duration of Therapy/Use:				
Medication request is NOT for an FDA- Diagno								1					
				iagnosis:	1			ICD-	10 Code:	:			
approved, or compend				iagnosis:				ICD-	10 Code:				
approved, or compend (circle one):	dia-supported			iagnosis:	1			ICD-	10 Code:				
approved, or compend (circle one):	dia-supported	l diagno	osis		sis? Ple	ease spec	cify:	ICD-	10 Code:				
approved, or compend (circle one): Yes What medication(s) ha	dia-supported No ave been tried	l diagno	osis		sis? Ple	ease spec	bify:	ICD-	10 Code:				
approved, or compend (circle one): Yes What medication(s) ha Turn-Around Time for	dia-supported No ave been tried r Review	l diagno	led for thi	is diagno		•	-						
approved, or compend (circle one): Yes What medication(s) ha	dia-supported No ave been tried r Review	l diagno l and fai Urge	led for thi	is diagno iting 24 h	ours for	standar	d decision	n could ser	iously ha		ealth, or a	bility to	
approved, or compend (circle one): Yes What medication(s) ha Turn-Around Time for	dia-supported No ave been tried r Review	l diagno l and fai Urge	led for thi	is diagno iting 24 h	ours for	standar	d decision		iously ha		ealth, or a	bility to	
approved, or compend (circle one): Yes What medication(s) ha Turn-Around Time for	dia-supported No ave been tried r Review	l diagno l and fai Urge	led for thi nt – If wai n maximu	is diagno iting 24 h	ours for	standar	d decision	n could ser	iously ha		ealth, or a	bility to	
approved, or compend (circle one): Yes What medication(s) ha Turn-Around Time for	dia-supported No ave been tried r Review	l diagno l and fai Urge regai	led for thi nt – If wai n maximu	is diagno iting 24 h	ours for	standar	d decision	n could ser	iously ha		ealth, or a	bility to	
approved, or compend (circle one): Yes What medication(s) ha Turn-Around Time for Standard – (24 ho Clinical Information Long-Acting Opic	dia-supported No ave been tried r Review urs)	l diagno l and fai Urge regai	led for thi nt – If wai n maximu	is diagno iting 24 h	ours for on, you	standar can ask	d decision for an exp	n could ser pedited dea	iously ha cision.	rm life, h	ealth, or a	-	
approved, or compend (circle one): Yes What medication(s) ha Turn-Around Time for Standard – (24 ho Clinical Information Long-Acting Opic The requested drug is	dia-supported No ave been tried r Review urs)	l diagno l and fai Urge regai	led for thi nt – If wai n maximu iture:	is diagno iting 24 h um functi	ours for on, you Sickle	standar can ask	d decision for an exp 	n could ser bedited dea	iously ha cision. Palliative/	rm life, h	ealth, or a Hospice		
approved, or compend (circle one): Yes What medication(s) ha Turn-Around Time for Standard – (24 ho Clinical Information Long-Acting Opic The requested drug is prescribed due to ONE	dia-supported No ave been tried r Review urs)	l diagno l and fai Urge regai Signa	Isis led for thi nt – If wai n maximu Iture:	is diagno iting 24 h um functi	ours for on, you Sickle Cell	standar can ask	d decision for an exp	n could ser bedited dea	iously ha cision.	rm life, h			
approved, or compend (circle one): Yes What medication(s) ha Turn-Around Time for Standard – (24 ho Clinical Information Long-Acting Opic The requested drug is prescribed due to ONE following:	dia-supported No No ave been tried r Review urs) bids being of the	I diagno	led for thi nt – If wai n maximu ature: Cance	is diagno iting 24 h um functi	ours for on, you Sickle Cell Disea	standar can ask	d decision for an exp Termin Conditi	al E	iously ha cision. Palliative/ End of life	rm life, h	Hospice	N	
approved, or compend (circle one): Yes What medication(s) ha Turn-Around Time for Standard – (24 ho Clinical Information Clinical Information Clinical Information The requested drug is prescribed due to ONE following: Is request for non-	dia-supported No No ave been tried r Review urs) Dids being of the	I diagno I and fai I and fai regai Signa	led for thi nt – If wai n maximu ature: Cance	is diagno iting 24 h um functi er	ours for on, you Sickle Cell Disea respon	standar can ask	d decision for an exp Termin Conditi erance, or	n could ser bedited dea	iously ha cision. Palliative/ End of life cation	rm life, h		N	
approved, or compend (circle one): Yes What medication(s) ha Turn-Around Time for Standard – (24 ho Clinical Information Long-Acting Opic The requested drug is prescribed due to ONE following:	dia-supported No No ave been tried r Review urs) bids being of the	I diagno I and fai I and fai regai Signa Signa Urge I Urge I vas to th	led for thi nt – If wai n maximu ature: Cance	is diagno iting 24 h um functi ur luncti adequate ulary alte	ours for on, you Sickle Cell Disea respon	standar can ask	d decision for an exp Termin Conditi erance, or	al E contraindi	iously ha cision. Palliative/ End of life cation	rm life, h	Hospice		
approved, or compend (circle one): Yes What medication(s) ha Turn-Around Time for Standard – (24 ho Clinical Information Long-Acting Opid The requested drug is prescribed due to ONE following: Is request for non- preferred	dia-supported No Ave been tried r Review urs) being of the Yes No	I diagno I and fai regai Signa Signa Urge regai to th be s	Int – If wai nt – If wai n maximu ature: Cance there ina ubmittee	is diagno iting 24 h um functi er adequate ulary alte 1.	ours for on, you Sickle Cell Disea respon rnatives	standar can ask se se se, intole se, intole	d decision for an exp Termin Conditi trance, or , docume	al E contraindi entation ne	iously ha cision. Palliative/ End of life cation eds to	rm life, h	Hospice	N	

requested dose based on their		□ Yes		🗆 No	monito	atient has beer pred regularly	□ Yes	□N	0			
history of opioid use? opioid use disorder? The patient's pain will be reassessed in the first month after the initial prescription or any dose increase AND every three months thereafter to ensure that clinically meaningful improvement and function outweigh risks to patient safety?									□ Yes		10	
Is this request for a continuation of the a patient who has been receiving an extended-release opioid agent for at le days?				s 🗆 No	ta	Is this request for a patient who has taken an immediate-release opioid for at least one week?					10	
Is this request for a r maintenance treatm					etoxification tre	□ Yes		10				
Short Acting O	pioids											
The requested drug is being prescribed due to ONE of the following:		Ca	Cancer [e 🗆 ase	Terminal Condition	 Palliative End of life 		Hospice		N/A	
Is request for non-	Yes	No	Was ther	e inadeq	uate respor	ise, intol	erance, or cor	ntraindication	□ Yes	🗆 No		/A
preferred			to the three formulary alternatives? If yes, documentation									
product?			needs to	1						□ Yes		
Is the patient able to safely take the requested dose based on their history of opioid use?			□ Yes □ No		been ev	Is the patient 19 years of age or younger and has been evaluated and will be monitored regularly for the development of opioid use disorder?						0
The requested drug	is being		□ Yes □ No		The pat	The patient's pain will be reassessed in the first						١o
prescribed for mode	rate to				month a	month after the initial prescription or any dose						
CHRONIC pain wher	e use of	an			increas	increase AND every three months thereafter to						
opioid analgesic is appropriate?					ensure	ensure that clinically meaningful improvement and						
						function outweigh risks to patient safety?						
Does the patient require extended treatm				ond 3 da					e of an	□ Yes		10
opioid analgesics is appropriate?					,							
Additional information the prescribing provider feels is important to this review. Please specify below or submit										nit medica	al rec	ords
Signature affirms th	nat infa-	mation of	von on th	e form i-	trucanda	001150	and roflacts	office notes				
Signature amirms tr	iat intor	mation gl	ven on th	s iorm is	and a	curate	and reflects	unice 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 to check the status of a request. Pennsylvania CHIP:1-800-822-2447.