



Fax completed prior authorization request form to 855-799-2553 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.**

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Pharmacy Coverage Guidelines are available at [www.aetnabetterhealth.com/virginia/providers/pharmacy/](http://www.aetnabetterhealth.com/virginia/providers/pharmacy/)

# Pharmacy Prior Authorization Request 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**.

<b>Member Information</b>			
Member Name (first & last):	Date of Birth:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>	Height:
Member ID:	City:	State:	Weight:

<b>Prescribing Provider Information</b>			
Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

<b>Dispensing Pharmacy Information</b>		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

<b>Requested Medication Information</b>			
Medication Name:	Strength:	Dosage Form:	
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

Check if requesting **brand** only (Must include copy of MedWatch form)

<b>Turn-Around Time For Review</b>	
<input type="checkbox"/> Standard - (24 hours)	<input type="checkbox"/> <b>Urgent</b> - 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 Description:** \_\_\_\_\_

2.  **New** request  
 Continuation of therapy request  
If yes, Please specify (circle one) 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 formulary 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. For Brand name requests, generic formulation from 2 different manufacturers is required along with MedWatch form.

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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**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 formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

7.  Yes  No Is request for a patient that is on an insulin pump? Make and Model: \_\_\_\_\_  
Note: One Touch products are formulary.

**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/virginia/providers/pharmacy](http://www.aetnabetterhealth.com/virginia/providers/pharmacy) for drug-specific criteria forms.

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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.

Medallion/FAMIS 4.0: 1-800-279-1878

CCC Plus: 1-855-652-8249