aetna™

Aetna Better Health®

Fax completed prior authorization request form to 877-309-8077 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 www.aetnabetterhealth.com/pennsylvania/providers/pharmacy

Monoamine Depletors
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently

REQUIRED: Medical records, including labs and weight or body surface area (BSA), to support diagnosis are required to be submitted

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			
Preferred Agents:	☐ Austedo	☐ Tetrabenazine	
Non-Preferred Agents:	☐ Ingrezza	☐ Other, Please Specify	

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	ICD-10 Code:		Diagnosis:
What medications(s) has member tried and failed for this diagnosis? Please specify below.			

Turn-Around Time	
☐ 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				
Will Austedo, tetrabenazine and Ingrezza be prescribed concurrently with one another?			☐ Yes	☐ No
Member has the following:	☐ Active suicidal thoughts or behavior	☐ Hepatic impairment (for Austedo and tetrabenazine)	☐ Untreated OR undertreated depression	☐ None apply

☐ **Tardive Dyskinesia – INITIAL REQUEST**					
Is diagnosis moderate to severe tardive dyskinesia?	☐ Yes	☐ No	Does member have an AIMS score of 3 or 4 on any one of the testing items 1 through 9?	☐ Yes	☐ No
Is the requested medication prescribed by, or in consultation with a neurologist or psychiatrist?				☐ Yes	☐ No
Has provider attempted alternative method to manage condition (dose reduction, discontinuation of offending medication OR switching to alterative agent such as atypical antipsychotic)?				☐ Yes	☐ No
Please specify which atypical antipsychotic was used:			Please specify time frame of stability on atypical antipsychotic:		

Is the request for Ingrezza?						☐ Yes	☐ No
Has the member had a T/F, intolerance, OR C/I to Austedo?						☐ Yes	☐ No
☐ **Tardive Dyskinesia – RENEWAL REQUEST**							
Was there improvement in AIMS score from baseline or maintained improvement thereafter?						☐ Yes	☐ No
Provider is monitoring for ALL the following:	☐ Suicidal thoughts and behaviors		☐ Hepatic dysfunction (for Austedo only)		☐ Emergent or worsening depression		
☐ **Huntington's Chorea – INITIAL REQUEST**							
Is the requested medication prescribed by or in consultation with a neurologist?						☐ Yes	☐ No
Is the diagnosis confirmed by genetic testing of a targeted mutation analysis, demonstrating a cytosine-adenine-guanine (CAG) trinucleotide expansion of 36 or more repeats in the Huntington (HTT) gene?	☐ Yes	☐ No	Does member have Unified Huntington's Disease Rating Scale (UHDRS) score ranging from 1 to 4 on any one of the Unified Huntington's Disease Rating Scale (UHDRS) chorea items 1 through 7?			☐ Yes	☐ No
☐ **Huntington's Chorea – RENEWAL REQUEST**							
Did member have improvement in total maximal chorea score from baseline or maintained improvement thereafter?						☐ Yes	☐ No
Provider is monitoring for ALL the following:	☐ Suicidal thoughts and behaviors		☐ Hepatic dysfunction (for Austedo only)		☐ Emergent or worsening depression		
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 to check the status of a request.
Pennsylvania CHIP:1-800-822-2447.