



**Medical Exception/Prior Authorization/Precertification\* Request for Prescription Medications**

Fax this form to: 1-877-269-9916 OR

Submit your request online at: [www.availity.com](http://www.availity.com)

Visit [www.aetna.com/formulary](http://www.aetna.com/formulary) to access our Pharmacy Clinical Policy Bulletins.

For FASTEST service, call 1-855-240-0535, Monday-Friday, 8 a.m. to 6 p.m. Central Time

Patient Information		Prescriber Information	
Patient Name		Today's Date	
Patient Insurance ID Number		Physician Name	
Patient Address, City, State, ZIP		Physician Address	
Home Telephone		M.D. Office Telephone Number	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient Date of Birth	M.D. Office Fax Number	
Diagnosis and Medical Information			
Medication		Strength	Frequency
Expected Length of Therapy	Quantity	Day Supply	If this is a continuation of therapy, how long has the patient been on the medication?
Is this medication being used to treat a chronic or long-term condition for which this prescription medication may be necessary for the life of the patient?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>PLEASE CHECK ALL BOXES THAT APPLY:</b>			
Do you want a drug specific prior authorization criteria form faxed to your office? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, no further questions are required).			
<input type="checkbox"/> What condition is the drug being prescribed for? ICD code _____ Diagnosis _____			
<input type="checkbox"/> Does the patient have a diagnosis of cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> <b>STEP THERAPY</b> may be required. Please list all medications the patient has tried specific to the diagnosis and specify below: Therapeutic failure, including length of therapy for each drug: _____ Drugs (s) contraindicated: _____ Adverse even (e.g., toxicity, allergy) for each drug: _____			
<input type="checkbox"/> Is the request for a patient with one or more chronic conditions (e.g., psychiatric condition, diabetes) who is stable on the current drug(s) and who might be at high risk for a significant adverse event with a medication change? If so, specify anticipated significant adverse event: _____			
<input type="checkbox"/> Has the condition been confirmed by diagnostic testing? If so, please provide diagnostic test and date: _____			
<input type="checkbox"/> Please provide any pertinent lab testing values for the members diagnosis : _____			
<input type="checkbox"/> Does the patient have a clinical condition for which other alternatives are not recommended based on published guidelines or clinical literature? If so, please provide documentation: _____			
<input type="checkbox"/> Does the patient require a specific dosage form (e.g., suspension, solution, injection)? If so, please provide dosage form: _____			
<input type="checkbox"/> Are additional risk factors (e.g., GI risk, cardiovascular risk, age) present? If so, please provide risk factors: _____			
<input type="checkbox"/> Other: Please provide additional relevant information: _____			
REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION. PLEASE COMPLETE CORRESPONDING SECTION ON BACK PAGE FOR THE SPECIFIC DRUG/CLASS LISTED BELOW. Antiemetic (5-HT3) Agents/Erectile Dysfunction Agents/Stimulants/ Provigil, Nuvigil/Testosterones			
**FOR ANY DRUG/CLASS NOT LISTED ON THE BACK PAGE, PLEASE ATTACH ADDITIONAL INFORMATION, BUT CANNOT EXCEED TWO PAGES** <b>PRESCRIPTION BENEFIT PLAN MAY REQUEST ADDITIONAL INFORMATION OR CLARIFICATION, IF NEEDED, TO EVALUATE REQUESTS</b>			

**Urgent Request: I certify that applying a standard review timeframe might seriously jeopardize the life or health of the patient.**

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733.

Prescriber Signature

Date

**Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**PLEASE COMPLETE CORRESPONDING SECTION FOR THESE SPECIFIC DRUGS/CLASSES LISTED BELOW AND CIRCLE THE APPROPRIATE ANSWER OR SUPPLY RESPONSE.**

**ERECTILE DYSFUNCTION: CIALIS, LEVITRA, VIAGRA, ALPROSTADIL:**

Does the patient require nitrate therapy on a regular OR on an intermittent basis, or is the patient currently taking another ED medication?  Yes  No

If a diagnosis of erectile dysfunction, is it due to neurogenic etiology, vasculogenic etiology, psychogenic etiology or mixed etiology?  Yes  No

Is it being used for symptomatic Benign Prostatic Hyperplasia (BPH)?  Yes  No

**ANTIEMETIC (5-HT3) AGENTS:**

Is the patient receiving moderate to highly emetogenic chemotherapy? Monthly frequency \_\_\_\_\_  Yes  No

Is the patient receiving radiation therapy? Monthly frequency \_\_\_\_\_  Yes  No

If the patient has a diagnosis of Hyperemesis Gravidarum, has the patient experienced an inadequate treatment response to two of the following medications?

Vitamin B6, doxylamine, promethazine (Phenergan), trimethobenzamide (Tigan) or metoclopramide (Reglan)?  Yes  No

**TOPICAL TESTOSTERONES REPLACEMENT (lab requirements):**

For testosterone replacement therapy, has the member been confirmed by one of the following  Yes  No

1. two total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available) which were drawn in the morning between 7:00 a.m. and 10:00 a.m. on two different days, OR

2. persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available) which were drawn in the morning between 7:00 a.m. and 10:00 a.m. on two different days

**PROVIGIL/NUVIGIL:**

If the patient has a diagnosis of Obstructive Sleep Apnea, is the patient currently using a continuous positive airway pressure (CPAP) machine or another device?  Yes  No

**ADHD STIMULANTS AND NON-STIMULANTS:**

Is this a renewal of existing therapy?  Yes  No

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),  
1-800-648-7817, TTY: 711,

Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies .*



Hawaiian	No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki 'ole 'ia kēia kōkua nei.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obụla, kpọọ nọmba nọ na kaadi njirimara gị
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢတၢ်ကမၤကျိၣ်တၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ် လၢတၢ်အိၣ်ဒီးအပူၤလၢတၢ်ကတၢၢ်အိၣ်အိၣ်ကိးဘၣ်လီၤတဲၣ်စီၣ်နီၣ်လၢတၢ်အိၣ်လၢတၢ်နီၣ်နီၣ် ၀ (၅၅) အလီၤတၢ်ကတၢၢ်
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بۆ دەسپێرێ کەمبێرێ بە خزمەتگۆزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی (ID) کارتێ خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທລະສັບໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डवरील क्रमांकावर फोन करा.
Marshallese	Ñan bōk jipañ kōn kajin ilo an ejjelōk wōñean ñan kwe, kwōn kallok nōmba eo ilo kaat in ID eo aṃ.
Micronesian-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áa ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó naaltsoos bee atah nílíigo nanitinígíí bee néého'dólzinígíí béésh bee hane'í biká'ígíí áajj' hólne'.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të koor yin ran de wëër de thokic ke cïn wëu kor keek tënɔŋ yin. Ke yin cɔl ran ye koc kuony në namba de abac tö në ID kard duñ de tiit de nyin de panakim köu.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.



