aetna™

Aetna Better Health®

Fax completed prior authorization request form to 855-799-2551 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/michigan/providers/medicaid/pharmacy

Biologic Immunomodulators
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				
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					
Non-Formulary Medications:	☐ Actemra SC	☐ Cimzia	☐ Cimzia Kit	☐ Entyvio	☐ Ilumya
	☐ Kevzara	☐ Kineret	☐ Olumiant	☐ Orencia	☐ Orencia SC
	☐ Otezla	☐ Rinvoq ER	☐ Siliq	☐ Simponi	☐ Simponi Aria
	☐ Skyrizi	☐ Sotyktu	☐ Stelara	☐ Taltz	☐ Tremfya
	☐ Xeljanz	☐ Xeljanz XR	☐ Xeljanz Solution	☐ Other, specify drug:	

Are there any contraindications to formulary medications? (if yes, please specify):	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request

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) have been tried and failed for this diagnosis? Please specify:		

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information					
Is this a request for a non-preferred product that has a unique FDA-approved indication?				☐ Yes	☐ No
Is the member clinically stable and switching would cause a deterioration in condition?	☐ Yes	☐ No	Has the member experienced a therapeutic failure with one preferred medication in the same subclass?	☐ Yes	☐ No
Does the member have any of the following to the preferred medication(s): (check all that apply)	☐ Allergy ☐ Contraindication or drug interactions ☐ History of unacceptable side effects				

Has the member experienced a trial and failure on one medication from EACH of the following classes: (check all that apply)	☐ Aminosalicylate [for example, mesalamine (Asacol HD, Pentasa, Lialda, Apriso, Delzicol), olsalazine (Dipentum), balsalazide (Colazal, sulfasalazine (Azulfidine)] ☐ Oral steroid ☐ Thiopurine [i.e., azathioprine (Imuran), mercaptopurine (Purinethol)] ☐ TNF (tumor necrosis factor) blocker [i.e., infliximab (Remicade, etanercept (Enbrel)]?		
Has the member had a trial and failure or inadequate response to methotrexate?		☐ Yes	☐ No
Does the member have a diagnosis of plaque psoriasis OR psoriatic arthritis with 3 or more swollen and tender joints?		☐ Yes	☐ No
Has this plan authorized this medication in the past for this member (i.e. previous authorization is on file under this plan)?		☐ Yes	☐ No
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 855-300-5528 to check the status of a request.