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

Oxervate
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			
Are there any contraindications to formulary medications?	☐ Yes ☐ No	If yes, 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	Diagnosis:		ICD-10 Code:
What medication(s) has the member tried and failed for this diagnosis? Please specify:			

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If 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		
Has the member or caregiver has been counseled on proper administration technique?	☐ Yes	☐ No
Is there documentation that the member has a diagnosis of stage 2 (recurrent/persistent epithelial defect) or stage 3 (corneal ulcer) neurotrophic keratitis in affected eye(s)?	☐ Yes	☐ No
Is there documentation that the member has tried and failed at least two conventional non-surgical treatments (for example preservative-free artificial tears, lubricant eye ointment, topical antibiotic eye drops, therapeutic contact lenses)	☐ 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 866-316-3784 to check the status of a request