aetna™

Aetna Better Health®

Fax completed prior authorization request form to 877-270-3298 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/maryland/providers/pharmacy

Dalfampridine
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 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				
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:		ICD-10 Code:	
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:	
What medication(s) has the member tried and failed for this diagnosis? Please specify below.				

Turn-Around Time for Review	
☐ 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					
Does member have an impaired walking ability defined as baseline 25-foot walking test between 8 AND 45 seconds?	☐ Yes	☐ No	Does member have an expanded Disability Status Scale between 4.5 AND 6.5?	☐ Yes	☐ No
Is member wheelchair bound?	☐ Yes	☐ No	Does member have history of seizures?	☐ Yes	☐ No
Has there been disease exacerbation in previous 60 days?	☐ Yes	☐ No	Does member have moderate to severe renal impairment (CrCl < 50 mL/min)?	☐ Yes	☐ No
☐ **Renewal Request ONLY**					
Was there improvement in timed walking speed on 25-foot walk?	☐ Yes	☐ No	Was there stability or improvement in Expanded Disability Status Scale score?	☐ Yes	☐ No
Does member have moderate to severe renal impairment CrCl <50 mL/min)?	☐ Yes	☐ No	Was an annual Electroencephalography test completed?	☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.					

Proprietary

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 866-827-2710 to check the status of a request.

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