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

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			
☐ Austedo	☐ Tetrabenazine		
Are there any hypersensitivity OR contraindications to formulary medications? (circle one): ☐ Yes ☐ No		☐ New request	☐ Continuation 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	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					
Member has the following:	☐ Active suicidal thoughts OR behavior	☐ Hepatic dysfunction	☐ Untreated OR undertreated depression	☐ Congenital long QT syndrome OR arrhythmias associated with prolonged QT interval	☐ None apply

☐ **Tardive Dyskinesia**					
Is diagnosis moderate to severe tardive dyskinesia?	☐ Yes	☐ No	Is AIMS score ≥6?	☐ 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:		

☐ **Renewal ONLY**					
Was there improvement in AIMS score (decrease from baseline by at least TWO points)?				☐ Yes	☐ No
Provider is monitoring for ALL the following:	☐ Suicidal thoughts and behaviors	☐ EKG, for members at risk for QT prolongation	☐ Hepatic dysfunction (for Austedo only)	☐ Emergent or worsening depression	

☐ **Huntington's Chorea**					
Is diagnosis confirmed by neurologist consult AND genetic testing?	☐ Yes	☐ No	Was there inadequate response OR intolerable side effects to amantadine?	☐ Yes	☐ No

Does member have Unified Huntington's Disease Rating Scale (UHDRS) total maximal chorea score of ≥8?			☐ Yes	☐ No
☐ **Renewal ONLY**				
Did member have improvement in Total Maximal Chorea score ≥3 points from baseline?			☐ Yes	☐ No
Provider is monitoring for ALL the following:	☐ Suicidal thoughts and behaviors	☐ EKG for members at risk for QT prolongation	☐ 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 866-827-2710 to check the status of a request.