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	☐ Other, please specify:		
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						
☐ **Huntington's Chorea**						
Is the requested medication prescribed by or in consultation with a neurologist?					☐ Yes	☐ No
Is the diagnosis confirmed by genetic testing of a targeted mutation analysis, demonstrating a cytosine-adenine-guanine (CAG) trinucleotide expansion of 36 or more repeats in the Huntington (HTT) gene?	☐ Yes	☐ No	Does member have Unified Huntington's Disease Rating Scale (UHDRS) score ranging from 1 to 4 on any one of the Unified Huntington's Disease Rating Scale (UHDRS) chorea items 1 through 7?		☐ Yes	☐ No
☐ **Renewal ONLY**						
Did member have improvement in total maximal chorea score from baseline or maintained improvement thereafter?					☐ Yes	☐ No
Is Austedo or tetrabenazine being prescribed concurrently with one another?					☐ Yes	☐ No
Provider is monitoring for ALL the following:	☐ Suicidal thoughts and behaviors		☐ Hepatic dysfunction	☐ 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.