

Fax completed prior authorization request form to 855-799-2553 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.

Aetna Better Health®

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/virginia/providers/pharmacy/

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

	<u> </u>			-			
Member Information						1	
Member Name (first & last):	Date o	Date of Birth:		Gender: M F		Height:	
Member ID:	City:	City:		State:		Weight:	
Prescribing Provider Information							
Provider Name (first & last):	Specia	ılty:		NPI#:		DEA#:	
Office Address:	City:	: State:		State:		Zip Code:	
Office Contact:	Office	fice Phone:			Office Fax:		
Dispensing Pharmacy Information					·		
Pharmacy Name:	Pharm	Pharmacy Phone:			Pharmacy Fax:		
Requested Medication Information					1		
Medication Name:	Streng	trength:			Dosage Form:		
Directions for Use:	Quanti	antity: Refills:		:	Duration of Therapy/Use:		
☐ Check if requesting brand only (Must include copy o	f MedWatch form)		I		I		
Turn-Around Time For Review							
Standard - (24 hours) Urgent - by waiting 24 ho					, health, or a	ability to regain	
Clinical Information	r don for all expodute	ra (last) a	001010111	orgridataro			
1. What is the diagnosis? Please specify below.	☐ Madigation rad	west is NC	T for on I	TDA approved a	ar aamaandis	a cumparted diagnacia	
ICD-10 Code:		luest is <u>inc</u>	<u>n</u> ior an i	-DA-approved, (or compendia	a-supported diagnosis	
	Diagnosis Descri	ption: _					
2. New request							
☐ Continuation of therapy request							
If yes, Please specify (circle one) how this medica							
Previous Prior Authorization, Paid under Another	Insurance, Recent I	Hospital D	ischarge	e or Other			
3. Yes No Are there any contraindications to formular	v medications?		□ No. I	s this a request	for an increa	se or decrease in dose or	
If yes, please specify:			☐Yes ☐ No Is this a request for an increase or decrease in dose or quantity of a previously approved medication?				
4. What medication(s) has the individual tried and f							
Important note: Samples provided by the prescriber are not acc generic formulation from 2 different manufacturers is required a			or as an	adequate trial a	nd failure. Fo	or Brand name requests,	
	Dates started and stopped or Approximate Duration		Reason therapy was discontinued				
	or representate by						
5. Are there any supporting labs or test results? Plantage Total	ease specify below	<u>'-</u>		•	/ala		
Date Test			Value				



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. Is there any additional information the prescribing provider feels is important to this review? Please specify below or submit nedical records. For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.						
Yes ☐ No	Is request for a patient that is on an insulin pump? Make and Model:					
	Note: One Touch products are formulary.					
gnature affirm	s that information given on this form is true and accurate and reflects office notes					
scribing Provider's	s Signature: Date:					

Please note:

Some medications may require completion of a drug-specific request form. Please refer to plan website at www.aetnabetterhealth.com/virginia/providers/pharmacy for drug-specific criteria forms.

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Standard turnaround time is 24 hours. You can call 1-800-279-1878 to check the status of a request.