aetna®

Medical Exception/ Prior Authorization/Precertification* Request for Prescription Medications

Fax this form to: 1-877-554-9139
OR
Visit www.**cvty.com** to access our Pharmacy Clinical Policy Bulletins.

For FASTEST service, call **1-877-215-4098**, Monday-Friday, 7 a.m. to 5 p.m. Central Time

Patient Information		**Prescriber Information**
Patient Name		Today's Date
Patient Insurance ID Number		Physician Name
Patient Address, City, State, ZIP		Physician Address
Home Telephone		M.D. Office Telephone Number
Gender ☐ **Male** ☐ **Female**	Patient Date of Birth	M.D. Office Fax Number

Diagnosis and Medical Information

Medication		Strength	Frequency
Expected Length of Therapy	Quantity	Day Supply	If this is a continuation of therapy, how long has the patient been on the medication?

PLEASE CHECK ALL BOXES THAT APPLY:

Do you want a drug specific prior authorization criteria form faxed to your office? ☐ Yes ☐ No **(If yes, no further questions are required).**

☐ What condition is the drug being prescribed for? ICD code _____

Diagnosis _____

☐ Does the patient have a diagnosis of cancer? ☐ Yes ☐ No

☐ Please list all medications the patient has tried specific to the diagnosis and specify below:

Therapeutic failure, including length of therapy for each drug: _____

Drugs (s) contraindicated: _____

Adverse even (e.g., toxicity, allergy) for each drug: _____

☐ Is the request for a patient with one or more chronic conditions (e.g., psychiatric condition, diabetes) who is stable on the current drug(s) and who might be at high risk for a significant adverse event with a medication change? If so, specify anticipated significant adverse event:

_____

☐ Has the condition been confirmed by diagnostic testing? If so, please provide diagnostic test and date:

_____

☐ Does the patient have a clinical condition for which other alternatives are not recommended based on published guidelines or clinical literature?

If so, please provide documentation: _____

☐ Does the patient require a specific dosage form (e.g., suspension, solution, injection)? If so, please provide dosage form:

_____

☐ Are additional risk factors (e.g., GI risk, cardiovascular risk, age) present? If so, please provide risk factors: _____

_____

☐ Other: Please provide additional relevant information: _____

_____

REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION.

PLEASE COMPLETE CORRESPONDING SECTION ON BACK PAGE FOR THE SPECIFIC DRUG/CLASS LISTED BELOW.

Antifungals/Antiemetic (5-HT3) Agents/Celebrex/Erectile Dysfunction Agents/Proton Pump Inhibitors/Protopic Provigil/Nuvigil/Stimulants/Tazorac/Tretinoin Products/Triptans

FOR ANY DRUG/CLASS NOT LISTED ON THE BACK PAGE, PLEASE ATTACH ADDITIONAL INFORMATION, BUT CANNOT EXCEED TWO PAGES

PRESCRIPTION BENEFIT PLAN MAY REQUEST ADDITIONAL INFORMATION OR CLARIFICATION, IF NEEDED, TO EVALUATE REQUESTS

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. *See, e.g.*, 31 U.S.C. §§ 3729-3733.

Prescriber Signature	**Date**

PLEASE COMPLETE CORRESPONDING SECTION FOR THESE SPECIFIC DRUGS/CLASSES LISTED BELOW AND CIRCLE THE APPROPRIATE ANSWER OR SUPPLY RESPONSE.

☐ **ANTIFUNGALS: LAMISIL, SPORANOX, PENLAC, DIFLUCAN**

Does the patient have secondary medical risk factors? Please specify which risk factor(s): _____

If the patient has a diagnosis of Onychomycosis, does the infection involve the toenails, fingernails or both? **Please circle**

If the diagnosis is Tinea corporis or Tinea cruris, does the patient require systemic therapy or have more extensive superficial infections? ☐ Yes ☐ No

☐ **ANTIEMETIC (5-HT3) AGENTS: (Ondansetron quantities of 12 or less per 30 days do not require a prior authorization)**

Is the patient receiving moderate to highly emetogenic chemotherapy? Monthly frequency _____ ☐ Yes ☐ No

Is the patient receiving radiation therapy? Monthly frequency _____ ☐ Yes ☐ No

If the patient has a diagnosis of Hyperemesis Gravidarum, has the patient experienced an inadequate treatment response to two of the following medications?

vitamin B6, doxylamine, promethazine (Phenergan), trimethobenzamide (Tigan) or metoclopramide (Reglan)? ☐ Yes ☐ No

☐ **CELEBREX:**

Is the patient at risk for a severe NSAID-related gastrointestinal (GI) adverse event (e.g., NSAID associated gastric ulcer, GI bleed)? ☐ Yes ☐ No

☐ **ERECTILE DYSFUNCTION: CIALIS, LEVITRA, VIAGRA, ALPROSTADIL**

Does the patient require nitrate therapy on a regular OR on an intermittent basis, or is the patient currently taking another ED medication? ☐ Yes ☐ No

If a diagnosis of erectile dysfunction, is it due to neurogenic etiology, vasculogenic etiology, psychogenic etiology or mixed etiology? **Please circle.**

Is it being used for symptomatic Benign Prostatic Hyperplasia (BPH)? ☐ Yes ☐ No

☐ **PROTON PUMP INHIBITORS:**

Does the patient have frequent and severe symptoms of GERD (e.g., heartburn, regurgitation)? ☐ Yes ☐ No

Does the patient have atypical symptoms or complications of GERD (e.g., dysphagia, hoarseness, erosive esophagitis)? ☐ Yes ☐ No

☐ **PROTOPIC:**

Has the patient had a therapeutic failure of a topical corticosteroid? ☐ Yes ☐ No

☐ **PROVIGIL/NUVIGIL:**

If the patient has a diagnosis of Obstructive Sleep Apnea, is the patient currently using a continuous positive airway pressure (CPAP) machine or other device? ☐ Yes ☐ No

☐ **STIMULANTS: AMPHETAMINES, METHYLPHENIDATES, STRATTERA**

Is this a renewal of therapy? ☐ Yes ☐ No

☐ **TAZORAC/ TRETINOIN PRODUCTS:**

Has the patient tried and failed products from the following categories: Salicylic Acid Products OR Benzoyl Peroxide products? ☐ Yes ☐ No

☐ **TRIPTANS:**

Is the patient currently using migraine prophylactic therapy (e.g., amitriptyline, propranolol, timolol)? ☐ Yes ☐ No