aetna SM

Return completed request and Medical Record documentation to:
Fax: 1-855-684-5250
If you have any questions, call:
Phone: 1-866-212-2851

AETNA BETTER HEALTH®

Pharmacy prior authorization form

Patient Information	Prescriber Information
Patient Name	Prescriber Name
Member ID#	NPI#(required)
Sex (circle) M F	Office Address
DOB	City, State, Zip Code
Home Phone:	Office Phone
	Office Fax
	Contact Person

Diagnosis and Medical Information			
Medication	Strength	Route of Administration	Frequency
☐ New Prescription OR Date Therapy Began		Expected Length of Therapy	Qty
Height/Weight	Allergies	Diagnosis	ICD9 Code
PRESCRIBER'S SIGNATURE			Date

FORM *CANNOT BE PROCESSED* without required explanation below and *SUPPORTING MEDICAL RECORDS*.

Rationale for Exception Request or Prior Authorization

- ☐ Alternate drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy, or therapeutic failure) and completed Multi-source Brand Drug Fax Form. **Specify:** (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s); (4) **Attach supporting clinical notes**

- ☐ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change. **Specify:** (1) Anticipated significant adverse clinical outcome; (2) **Attach supporting clinical notes**

- ☐ Medical need for different dosage form and/or higher dosage; **Specify:** (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason; (3) **Attach supporting clinical notes**

- ☐ Other: _____ (1) Explain below; (2) **Attach supporting clinical notes**

Required Explanation