

USE FOR MEDICARE DRUG PLAN PARTICIPANTS ONLY



Medical Exception/Precertification* Request Form for Prescription Medications

**For FASTEST service,
CALL 1-800-414-2386**

Monday-Friday 8:00 am to 5:00 p.m Local Time - Continental US
Fax to: 1-800-408-2386 or email: <https://www.aetna.com/provweb/>
Visit www.aetna.com/formulary to access the Pharmacy Clinical Policy Bulletins

Patient Name _____ Today's Date _____
Patient Insurance ID # _____ Patient Date of Birth _____
LTC/MD Office Phone (_____) _____ LTCPharmacy/Physician Name (print) _____
LTC/MD Office Fax (_____) _____ LTC Pharmacist/Physician Signature _____

COX-II INHIBITOR requested: **In order to process your request, ALL applicable fields MUST be completed**

CELEBREX^{NP}

Diagnosis (check all that apply)

- Osteoarthritis Rheumatoid Arthritis Acute Pain Chronic Pain
 Familial Adenomatous Polyposis (FAP) JRA Other: _____

Does the patient have a history of ulcer disease or GI bleed? Yes No
Is the patient currently using anticoagulants, antiplatelets, or corticosteroids? Yes No
Does the patient have a serious GI disease requiring therapy with an H2RA or PPI? Yes No
If so, what is their GI diagnosis: _____
Was a PPI or H2RA started as a result of NSAID-induced GI effects? Yes No

Previous Therapy (check all that apply)

- ibuprofen (doses > 200 mg) naproxen/EC (doses > 220 mg) nabumetone ketoprofen
 etodolac/SR diclofenac/K/SR Other _____

Additional Information _____

PROTON PUMP INHIBITOR requested: **In order to process your request, ALL applicable fields MUST be completed**

- omeprazole^P PREVACID^P PROTONIX^P NEXIUM^P ACIPHEX^{NP} PRILOSEC^{NP} ZEGERID^{NP}

Dose requested _____ mg QD BID TID Other _____

Diagnosis (check all that apply)

- GERD w/nocturnal acid breakthrough GERD Barrett's esophagus Hypersecretory condition
 H. pylori Laryngopharyngeal reflux Other _____

Previous therapy, including OTCs _____ NONE Dates (if available) _____

HMG Co-A requested:

In order to process your request, ALL applicable fields MUST be completed

- LIPITOR^P CRESTOR^P VYTORIN^P ZETIA^P lovastatin (GENERIC)^P pravastatin (GENERIC)^P
 simvastatin (GENERIC)^P ADVICOR^{NP} CADUET^{NP} MEVACOR^{NP} LESCOL/LESCOL XL^{NP}
 PRAVACHOL^{NP} ZOCOR^{NP} OTHER _____

Diagnosis (check all that apply):

- Hypercholesterolemia Mixed lipidemia Hyperlipidemia Other: _____

Previous HMG therapy: _____ Strength: _____ Current HMG therapy: _____ Strength: _____

Current LDL: _____ Goal LDL: _____ Percent LDL Reduction required: _____ %

For ALL other requests:

In order to process your request, ALL applicable fields MUST be completed

Drug requested: _____ Duration of therapy: _____ Diagnosis: _____

Previous therapy, including OTCs _____ NONE Dates (if available) _____

For Additional Quantities: Drug: _____ Strength(s): _____

Provide the specific dosing schedule, including number of tablets per dose & number of doses per day: _____

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ANTIFUNGAL requested: **In order to process your request, ALL applicable fields MUST be completed**

LAMISIL^P fluconazole (generic)^P DIFLUCAN^{NP} PENLAC^{NP} SPORANOX^{NP} VFEND^{**NP}

**On what date did the member begin therapy with this medication? _____

Diagnosis (check all that apply)

Onychomycosis (*SEE BELOW*) (Circle) Tinea capitis / pedis / cruris / corporis Vulvovaginal candidiasis
 Oral candida (thrush) Other _____

Previous therapy, including OTCs _____ NONE Dates (if available) _____

PLEASE COMPLETE FOR DIAGNOSIS: ONYCHOMYCOSIS

Fungal Lab Test Result: Positive Negative Test Date: _____ Location: Fingernail(s) Toenail(s)

Other existing conditions (check all that apply)

Pain-Limiting activity Diabetes Mellitus Systemic dermatosis Immunosuppression (AIDS, cancer)

CCB requested: **In order to process your request, ALL applicable fields MUST be completed**

CALAN^{NP} CALAN SR^{NP} CARDIZEM^{NP} CARDIZEM CD^{NP} COVERA HS^{NP} DILACOR XR^{NP}
 ISOPTIN SR^{NP} TIAZAC^{NP} VERELAN^{NP} VERELAN PM^{NP} ADALAT CC^{NP} PLENDIL^{NP}
 DYNACIRC CR^{**NP} CARDENE SR^{NP} PROCARDIA^{NP} PROCARDIA XL^{NP} SULAR^{**NP}

Strength: _____ **Dosing Schedule:** _____

Previous Therapies (all medications listed below are preferred):

verapamil cr/er/sr (generic forms only) diltiazem cd/cr/er/sr/xt (generic forms only) diltia xt
 cartia xt felodipine (generic) CARDIZEM LA
 nifedipine (generic forms only) nifedical xl (generic forms only) NIMOTOP
 nifedipine cr/er (generic forms only) OTHER _____ NORVASC

**On what date did the member begin therapy with this medication? _____

Previous therapy: _____ NONE

ANTIDEPRESSANT requested: **In order to process your request, ALL applicable fields MUST be completed**

CYMBALTA^{**P} WELLBUTRIN XL^P EFFEXOR XR^{**P} PAXIL CR^{NP} LEXAPRO^{**NP}
 PROZAC WEEKLY^{NP} SARAFEM^{NP} EFFEXOR^{**NP} ZOLOFT^{**NP}

Previous therapies – Please check brand or generic:

<input type="checkbox"/> EFFEXOR XR	<input type="checkbox"/> CYMBALTA	<input type="checkbox"/> LEXAPRO	<input type="checkbox"/> WELLBUTRIN XL	<input type="checkbox"/> NONE	
PAXIL	<input type="checkbox"/> Generic	<input type="checkbox"/> Brand	PROZAC	<input type="checkbox"/> Generic	<input type="checkbox"/> Brand
WELLBUTRIN SR	<input type="checkbox"/> Generic	<input type="checkbox"/> Brand	CELEXA	<input type="checkbox"/> Generic	<input type="checkbox"/> Brand
REMERON	<input type="checkbox"/> Generic	<input type="checkbox"/> Brand	DESYREL	<input type="checkbox"/> Generic	<input type="checkbox"/> Brand
LUVOX	<input type="checkbox"/> Generic	<input type="checkbox"/> Brand	WELLBUTRIN	<input type="checkbox"/> Generic	<input type="checkbox"/> Brand
EFFEXOR	<input type="checkbox"/> Generic	<input type="checkbox"/> Brand	ZOLOFT	<input type="checkbox"/> Generic	<input type="checkbox"/> Brand

**On what date did the member begin therapy with this medication? _____ Diagnosis: _____

For ALL other requests: **In order to process your request, ALL applicable fields MUST be completed**

Drug requested: _____ Duration of therapy: _____ Diagnosis: _____

Previous therapy, including OTCs _____ NONE Dates (if available) _____

For Additional Quantities Drug: _____ Strength(s): _____

Provide the specific dosing schedule, including number of tablets per dose & number of doses per day: _____

*The term precertification means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage. It does not mean precertification as defined by Texas law, as a reliable representation of payment of care or services to fully insured HMO and PPO members.

