aetna®

Specialty Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Oncologist** ☐ **Hematologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Drug request is for: _____
Dose: _____ **Frequency:** _____ **Route**: _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Diagnosis: _____ Primary ICD Code: _____ Secondary ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

This form is for use ONLY where a drug specific specialty medication precertification request form does not exist.
For all requests (Clinical documentation must be submitted with all drug requests)

☐ Yes ☐ No Has the patient been treated with another medication for this diagnosis?
→ Please provide the name of the previous medication(s): _____
Please provide the date range of previous treatment: ____/____/____ - ____/____/____
____/____/____ - ____/____/____

☐ Yes ☐ No Was treatment with this medication ineffective, not tolerated, or contraindicated?
→ Please select which one applies to the previous treatment: ☐ Ineffective ☐ Not tolerated ☐ Contraindicated
Please explain answer: _____

☐ Yes ☐ No Has this condition been confirmed by diagnostic testing?
→ Please provide the diagnostic test name and date performed: Test name: _____ Date: ____/____/____

Please provide any relevant laboratory data specific to this drug request (e.g. complete blood count, liver transaminase, bilirubin, TB testing, pregnancy test, genetic testing): Name of test(s): _____
Test results: _____
Date(s) of testing: _____

Please list any other relevant information specific to this medication request: _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)* - Required clinical information must be completed for ALL precertification requests.

For oncology requests (must complete this section in addition to information above)

Please list current cancer stage: _____

Please identify the current disease state: ☐ Progressive ☐ Relapsed ☐ Refractory ☐ Unresectable ☐ Metastatic ☐ Advanced

Please identify how the medication will be used: ☐ First line therapy ☐ Second line therapy ☐ Subsequent therapy

Will the medication be used as a single agent or in combination with another medication? ☐ Single agent ☐ In combination with another medication

→ If used in combination with another medication, list the medication here: _____

☐ Yes ☐ No Is this medication FDA approved in this particular setting?

→ ☐ Yes ☐ No Is this medication recommended by NCCN in this particular setting?

→ Please select one of the following: ☐ NCCN Category 1 ☐ NCCN Category 2A ☐ NCCN Category 2B ☐ NCCN Category 3

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.