



MEDICARE FORM

Specialty Medication Precertification Request

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Page 1 of 3

(All fields must be completed and legible for precertification review.)

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

<p>For Aetna Medicare Advantage and Allina Health Aetna Medicare Members send request to: Phone: 1-866-503-0857 (TTY: 711) Fax: 1-844-268-7263 Availity: https://www.aetna.com/health-care-professionals/resource-center/availability.html</p>
<p>For Aetna Medicare FIDE (HMO-DSNP) Virginia Dual Eligible Special Needs Plans send request to: Phone: 1-855-463-0933 Fax: 1-833-280-5224 Availity: https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal</p>
<p>For Aetna Medicare FIDE (HMO-DSNP) New Jersey Dual Eligible Special Needs Plans send request to: Phone: 1-844-362-0934 Fax: 1-833-322-0034 Availity: https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html</p>
<p>For Aetna Medicare FIDE (HMO D-SNP) Illinois Dual Eligible Special Needs Plans send request to: Phone: 1-866-600-2139 FAX: 1-855-320-8445 Availity: https://www.aetnabetterhealth.com/illinois/providers/portal</p>
<p>For Aetna Medicare HIDE (HMO D-SNP) Michigan Dual Eligible Special Needs Plans send request to: Phone: 1-855-676-5772 Fax: 1-844-241-2495 Availity: https://www.aetnabetterhealth.com/michigan/providers/portal.html</p>



MEDICARE FORM Specialty Medication Precertification Request

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Page 2 of 3

(All fields must be completed and legible for precertification review.)

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:		DOB:	
Address:			City:		State: ZIP:
Home Phone:		Work Phone:		Cell Phone: E-mail:	
Current Weight: ____ lbs or ____ kgs		Height: ____ inches or ____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:		State: ZIP:
Phone:		Fax:		St Lic #: NPI #: DEA #: UPIN:	
Provider E-mail:			Office Contact Name:		Phone:
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Hematologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ Address: _____		Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____	
---	--	--	--

E. PRODUCT INFORMATION

Drug request is for: _____ HCPCS code: _____ 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: _____



MEDICARE FORM

Specialty Medication Precertification Request

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Page 3 of 3

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

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.