MEDICARE FORM

Zilretta (triamcinolone acetonide extended-release) Injectable Medication Precertification Request

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

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

Note: Zilretta is non-preferred. The preferred products are Depo-Medrol, Kenalog, methylprednisolone acetate and triamcinolone acetate.

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.

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/availity.html
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
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
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
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

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Please indicate: ☐ Start of treatment: Start date ____/____/____ ☐ Continuation of therapy (Request Additional Series Below)

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

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

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

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

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 Email:	Office Contact Name:		Phone:		

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy:
☐ *Outpatient Dialysis Center* ☐ Physician's Office
☐ Retail Pharmacy ☐ Specialty Pharmacy
☐ Mail Order ☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: ☐ Zilretta **HCPCS Code:** _____

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

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code**: _____

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

For Initiation Requests (clinical documentation required for all requests):

Note: Zilretta is non-preferred. The preferred products are Depo-Medrol, Kenalog, methylprednisolone acetate and triamcinolone acetate.

☐ Yes ☐ No Has the patient had documented inadequate response to a trial of two or more of the following? (If yes, select all that apply)
Medical records (e.g., chart notes) documenting an inadequate to a trial of two or more preferred products must be available upon request.
☐ Depo-Medrol ☐ Kenalog ☐ methylprednisolone acetate ☐ triamcinolone acetate
→ When was the member's inadequate response to the preferred drug(s)? _____
→ Please describe the nature of the inadequate response to the preferred drug(s) _____

☐ Yes ☐ No Has the patient had a documented intolerable adverse event to two or more of the following? (If yes, select all that apply)
Medical records (e.g., chart notes) documenting an intolerable adverse event to two or more preferred products must be available upon request.
☐ Depo-Medrol ☐ Kenalog ☐ methylprednisolone acetate ☐ triamcinolone acetate
→ When was the member's intolerable adverse event to the preferred drug(s)? _____
→ Please describe the nature of the intolerable adverse event to the preferred drug(s) _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following (select all that apply)

☐ Depo-Medrol ☐ Kenalog ☐ methylprednisolone acetate ☐ triamcinolone acetate

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Does the patient have documented osteoarthritis (OA) of the knee?

Which knee will be injected with Zilretta? (select all that apply)

☐ Right ☐ Left

☐ Yes ☐ No Has the patient previously received treatment with the requested drug for the same knee?

☐ Yes ☐ No Is the request for more than one dose per knee?

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.