



## Specialty Medication

### Medical Prior Authorization Request

If you're asking for precertification for a Medicare Advantage member, please refer to the Medicare fax forms.

Your patient's benefit plan requires prior authorization (also referred to as PA or precertification) before certain medications may be covered. Go to [Precertification – Health Care Professionals | Aetna](#) to learn more about this process. In order to make appropriate medical necessity determinations, your patient's diagnosis and other relevant clinical information and documentation are required for all requests. We may request additional information or clarification, if needed, to evaluate requests. **To initiate the review process, please complete the information requested on the form below and fax along with supporting clinical documentation to 1-888-267-3277.** If you have questions regarding the prior authorization, please call 1-866-752-7021 (TTY: 711).

<b>Patient Name:</b>	<b>Date:</b>
<b>Patient Address:</b> City: State: ZIP:	<b>Patient's Date of Birth:</b> <b>Patient's Phone:</b>

<b>Aetna Member ID #:</b> <b>Group #:</b>	<b>Does patient have other coverage:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, provide ID#:</b> <b>Carrier Name:</b>
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<b>Requesting Physician's Name:</b> <b>Address:</b> City: State: ZIP:	<b>NPI #:</b> <b>Provider Tax ID:</b> <b>Provider ID:</b>
<b>Specialty:</b> <b>Physician Office Telephone:</b> <b>Physician Office Contact Name:</b>	<b>Select one:</b> <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A. <b>Physician Office Fax:</b> <b>Phone:</b>

<b>Rendering Provider Info:</b> <input type="checkbox"/> Same as Requesting Provider <b>Name:</b> <b>Address:</b> City: State: ZIP: <b>Phone:</b>	<b>NPI:</b> <b>Provider Tax ID:</b> <b>Provider ID:</b>  <b>Fax:</b>
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<b>Place of Service:</b> Please indicate the place of service for the requested drug: <input type="checkbox"/> Home (POS Code 12) <input type="checkbox"/> Outpatient Hospital (POS Code 19, 22) <input type="checkbox"/> Office (POS Code 11) <input type="checkbox"/> Self-administered
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If place of service is not dispensing the drug, please indicate the dispensing pharmacy:

<b>Name:</b> <b>Address:</b> City: State: <b>Phone:</b>	<b>NPI:</b> <b>Provider Tax ID:</b> <b>Provider ID:</b>  <b>Fax:</b>
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**Send completed form to: 1-888-267-3277**

Note: This document may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received this in error, please immediately notify the sender by telephone and destroy the original message.

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**Please indicate the following:**

For new requests, treatment start date: \_\_\_\_\_

For continuation requests, date of last treatment: \_\_\_\_\_

Allergies: \_\_\_\_\_

For Delaware only: Is this medication being used to treat a chronic or long-term condition for which this prescription medication may be necessary for the life of the patient?      Yes    No

**Required Demographic Information:**

Patient Current Weight: \_\_\_\_\_  lbs    kgs

Patient Height: \_\_\_\_\_  inches    cms

**Drug Information:**

Request is for:

Strength:

Dose:

Frequency:

Route of Administration:

**Diagnosis Information:**

Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code:

Secondary ICD Code:

Other ICD Code:

*Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.*

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Required clinical information must be completed in its entirety for all authorization requests. Clinical documentation must be submitted with all drug requests. We may request additional information or clarification, if needed, to evaluate requests.

**Criteria Questions:**

1. Please indicate the diagnosis that applies to this request: \_\_\_\_\_, *Continue to 2*
2. Has the patient been treated with another medication for this diagnosis?  
 Yes, *Continue to 3*  
 No, *Continue to 6*
3. Please provide the name of the previous medication(s): \_\_\_\_\_, *Continue to 4*
4. Please provide the date range of the previous treatment: \_\_\_\_\_, *Continue to 5*
5. Was treatment with the previous medication ineffective, not tolerated or contraindicated?  
 Ineffective, *Continue to 6*  
 Not tolerated, *Continue to 6*  
 Contraindicated, *Continue to 6*  
 Other, please specify. \_\_\_\_\_, *Continue to 6*
6. Has this condition been confirmed by diagnostic testing?  
 Yes, *Continue to 7*  
 No, *Continue to 8*
7. Please indicate the diagnostic test name, the date performed and the results: \_\_\_\_\_, *Continue to 8*
8. Has the patient had any relevant laboratory data specific to this medication request (e.g. complete blood count, liver transaminase, bilirubin, TB testing, pregnancy test, genetic testing)?  
 Yes, *Continue to 9*  
 No, *Continue to 10*
9. Please indicate the name of the test(s), test result and date(s) the test was performed: \_\_\_\_\_, *Continue to 10*
10. Please list any other relevant information specific to this medication request (Please attach all relevant documentation for consideration in this review (e.g. progress notes, laboratory testing, diagnostic testing, medication history, etc.):  
\_\_\_\_\_, *Continue to 11*
11. Is the requested medication for treatment of cancer?  
 Yes, *Continue to 14*  
 No, *Continue to 12*
12. Is the request for initiation or continuation of the requested medication?  
 Initiation, *No Further Questions*  
 Continuation, *Continue to 13*
13. Is there clinical documentation of disease stability or improvement?  
 Disease stability, *No Further Questions*  
 Improvement, *No Further Questions*  
 None of the above, *No Further Question*
14. Please indicate the current cancer stage: \_\_\_\_\_, *Continue to 15*

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15. Please indicate the current disease stage:

- Progressive, *Continue to 16*
- Relapse, *Continue to 16*
- Refractory, *Continue to 16*
- Unresectable, *Continue to 16*
- Metastatic, *Continue to 16*
- Advanced, *Continue to 16*
- Other, please specify. \_\_\_\_\_, *Continue to 16*

16. Please indicate how the requested medication will be used:

- First line therapy, *Continue to 17*
- Second line therapy, *Continue to 17*
- Subsequent therapy, *Continue to 17*
- Other, please specify. \_\_\_\_\_, *Continue to 17*

17. Will the medication be used as a single agent or in combination with another medication?

- Single agent, *Continue to 18*
- In combination with another medication (please indicate medication name(s) \_\_\_\_\_), *Continue to 18*

18. Is the medication FDA approved for use in this particular setting?

- Yes, *No Further Questions*
- No, *Continue to 19*

19. Is the medication recommended by NCCN for use in this particular setting?

- Yes, *Continue to 20*
- No, *No Further Questions*

20. Please indicate the NCCN category:

- NCCN Category 1, *Continue to 21*
- NCCN Category 2A, *Continue to 21*
- NCCN Category 2B, *Continue to 21*
- NCCN Category 3, *Continue to 21*

21. Is the request for initiation or continuation of the requested medication?

- Initiation, *No Further Questions*
- Continuation, *Continue to 22*

22. Is there evidence of disease progression or unacceptable toxicity?

- Disease progression, *No Further Questions*
- Unacceptable toxicity, *No Further Questions*
- Other, please specify. \_\_\_\_\_, *No Further Questions*

**I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested.**

**X** \_\_\_\_\_  
**Prescriber or Authorized Signature** **Date (mm/dd/yy)**

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.

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