Aetna®

Medical Exception/Precertification* Request Form for Prescription Medications

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

Monday-Friday 8:00 am to 7:00 pm Central Time

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_____

MD Office Phone (_____)_____ Physician Name (print)_____

MD Office Fax (_____)_____ Physician Signature (**REQUIRED**)_____

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

☐ ALLEGRA[NP] ☐ ALLEGRA-D[NP] ☐ CLARINEX[NP] ☐ CLARINEX-D[NP]

☐ *fexofenadine (generic)*[NP] ☐ SEMPREX-D[NP] ☐ ZYRTEC[NP] ☐ ZYRTEC-D[NP]

Diagnosis *(check all that apply)*

☐ Allergic rhinitis ☐ Chronic idiopathic urticaria ☐ Asthma ☐ Angioedema ☐ Other: _____

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

Additional Information_____

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

☐ PREVACID[P] ☐ ACIPHEX[P] ☐ *omeprazole*[P] ☐ NEXIUM[NP] ☐ PROTONIX[NP] ☐ PRILOSEC[NP] ☐ ZEGERID[NP]

Dosage 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*) _____

Additional Information_____

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]

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*) _____

Additional Information_____

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)

☐ Peripheral vascular disease ☐ Other _____

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:_____

_____

For **Accutane/isotretinoin** If female, pregnancy test results: _____ Test Date: _____

*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.

P=Aetna Preferred Drug; NP=Aetna Non-Preferred Drug

Medical Exception/Precertification* Request Form for Prescription Medications

For *FASTEST* service,
CALL 1-800-414-2386
Monday-Friday 8:00 am to 7:00 pm Central Time
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:_____
MD Office Phone (_____): _____ Physician Name (print): _____
MD Office Fax (_____):_____ Physician Signature (**REQUIRED**):_____

HMG Co-A requested: **In order for us to process your request, ALL applicable fields MUST be completed**

☐ ZOCOR[P] ☐ VYTORIN[P] ☐ LESCOL/LESCOL XL[P] ☐ *lovastatin* (*GENERIC*)[P] ☐ ADVICOR[P] ☐ LIPITOR[NP]
☐ PRAVACHOL[NP] ☐ PRAVIGARD[NP] ☐ MEVACOR[NP] ☐ ALTOPREV[NP] ☐ CRESTOR[NP] ☐ CADUET[NP]

Diagnosis *(check all that apply)*:
☐ Hypercholesterolemia ☐ Mixed lipidemia ☐ Hyperlipidemia ☐ Other: _____

Previous HMG therapy: _____ Strength: _____ ☐ NONE
Dates (*if available*): _____
Additional Information:_____

CNS STIMULANT requested: **In order for us to process your request, ALL applicable fields MUST be completed**

☐ ADDERALL XR[P] ☐ METADATE CD/ER[P] ☐ CONCERTA[NP] ☐ STRATTERA[NP] ☐ PROVIGIL[NP] ☐ RITALIN LA/SR[NP]

Diagnosis *(check all that apply)*:
☐ ADD ☐ ADHD ☐ Narcolepsy ☐ MS fatigue ☐ Idiopathic hypersomnia
☐ OSA (Obstructive Sleep Apnea) ☐ Other_____

Previous therapy: _____ ☐ NONE
Dates (*if available*): _____ Additional Information:_____

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

☐ PAXIL CR[P] ☐ EFFEXOR XR[P] ☐ WELLBUTRIN XL[P] ☐ CYMBALTA[NP] ☐ EFFEXOR[NP]
☐ ZOLOFT[NP] ☐ LEXAPRO[NP] ☐ PROZAC WEEKLY[NP]

Diagnosis *(check all that apply)*:
☐ Major depressive disorder ☐ Generalized anxiety disorder (GAD) ☐ Social anxiety disorder (SAD)
☐ Perimenopausal hot flashes ☐ **DIABETIC** peripheral neuropathic pain ☐ Other _____

Previous therapies – Please check brand or generic: ☐ **NONE**

☐ **Paxil CR**	**Paxil**	☐ Generic	☐ Brand	**Prozac**	☐ Generic	☐ Brand
☐ **Zoloft**	**Wellbutrin SR**	☐ Generic	☐ Brand	**Celexa**	☐ Generic	☐ Brand
☐ **Lexapro**	**Remeron**	☐ Generic	☐ Brand	**Desyrel**	☐ Generic	☐ Brand
☐ **Wellbutrin XL**	**Luvox**	☐ Generic	☐ Brand			

Additional Information:_____

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:_____
_____
For **Accutane/isotretinoin** If female, pregnancy test results: _____ Test Date: _____

*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.

P=Aetna Preferred Drug; **NP**=Aetna Non-Preferred Drug