aetna™

Aetna Better Health®

Fax completed prior authorization request form to 855-296-0323 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/newjersey/providers/pharmacy

Atypical Antipsychotics
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone		Office Fax:

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information					
Preferred:	☐ **ziprasidone**	☐ **clozapine**	☐ **quetiapine**	☐ **risperidone**	☐ **olanzapine**
Non-Preferred:	☐ aripiprazole	☐ paliperidone ER	☐ quetiapine ER	☐ Saphris	
	☐ Vraylar	☐ Fanapt	☐ Latuda	☐ Rexulti	

Are there any contraindications to formulary medications? (If yes, please specify):	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request Is member new to Plan and/or using samples for a non-preferred antipsychotic? (circle one): Yes ☐ No ☐
Is request for more than one antipsychotic due to a needed 60-day cross titration? (circle one): Yes ☐ No ☐				Did member start on the non-preferred antipsychotic during recent hospitalization? (circle one): Yes ☐ No ☐

Medication request is NOT for an FDA-approved, or compendia-supported diagnosis (circle one): Yes ☐ No ☐

What is the diagnosis ICD-10 Code?	Diagnosis:		
Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information Children Ages 6-17 Years		
Criteria for ALL indications:		
Is blood glucose using hemoglobin A1c (HBA1c) or blood glucose completed at baseline and then yearly?	☐ Yes	☐ No
Is cholesterol testing using the LDL-C or cholesterol completed at baseline and then yearly?	☐ Yes	☐ No

Is the weight completed at baseline and then yearly?	☐ Yes	☐ No	
Are the screenings for movement disorders associated with antipsychotic therapy completed?	☐ Yes	☐ No	
If member is a new start, are residual symptoms continuing despite use non-pharmacologic therapies such as behavioral, cognitive, and family based therapies?	☐ Yes	☐ No	☐ N/A

Additional Criteria Based on Indication				
Bipolar Disorder	**Schizophrenia**	**Psychomotor Agitation Associated with Autism Spectrum Disorder**	**Chronic Tic Disorder**	**Tourette's Syndrome**
Is requested antipsychotic a preferred formulary agent?			☐ Yes	☐ No
Was there an inadequate response, or intolerable side effect to 2 preferred formulary agents?			☐ Yes	☐ No

Major Depressive Disorder		
Was there inadequate response, or intolerable side effect to 3 different medication regimens for depression for at least 4 weeks?	☐ Yes	☐ No
Did medication regimen include antidepressant monotherapy?	☐ Yes	☐ No
Did medication regimen include an antidepressant augmentation with a SSRI or SNRI + bupropion, or Lithium, or buspirone, or liothyronine?	☐ Yes	☐ No
Is the requested antipsychotic a preferred formulary agent?	☐ Yes	☐ No
Was there inadequate response, or intolerable side effect to 2 preferred formulary atypical antipsychotics?	☐ Yes	☐ No

<u>Clinical Information Adults Age 18 Years and Older</u>

Criteria for ALL indications		
Is blood glucose using hemoglobin A1c (HBA1c) or blood glucose completed at baseline and then yearly?	☐ Yes	☐ No
Is cholesterol testing using the LDL-C or cholesterol completed at baseline and then yearly?	☐ Yes	☐ No
Is the weight completed at baseline and then yearly?	☐ Yes	☐ No
Are the screenings for movement disorders associated with antipsychotic therapy completed?	☐ Yes	☐ No

Additional Criteria Based on Indication			
Bipolar Disorder	**Schizophrenia**		
Was there inadequate response, or intolerable side effect to 2 preferred formulary atypical antipsychotics?		☐ Yes	☐ No

Major Depressive Disorder		
Was there inadequate response, or intolerable side effect to 3 different medication regimens for depression for at least 4 weeks?	☐ Yes	☐ No
Did medication regimen include antidepressant monotherapy?	☐ Yes	☐ No
Did medication regimen include an antidepressant augmentation with a SSRI or SNRI + bupropion, or Lithium, or buspirone, or liothyronine?	☐ Yes	☐ No
Was there inadequate response, or intolerable side effect to 2 preferred formulary atypical antipsychotics?	☐ Yes	☐ No

<u>Children Age 5 and Under</u>

Are residual symptoms continuing despite use non-pharmacologic therapies such as behavioral, cognitive, and family based therapies?	☐ Yes	☐ No
Was baseline and routine monitoring of weight, BMI or waist circumference completed?	☐ Yes	☐ No
Was baseline and routine monitoring of BP, fasting glucose, or fasting lipid panel completed?	☐ Yes	☐ No
Was baseline and routine monitoring of tardive dyskinesia using Abnormal Involuntary Movement Scale (AIMS) or Dyskinesia Identification System (DISCUS) completed?	☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.
Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call 855-232-3596 to check the status of a request