



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

Aetna Better Health®

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

Interferons 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: | |
| | | | | <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Member ID: | | City: | | State: | |
| | | | | Height: | |
| | | | | 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 | | | | | |
| <input type="checkbox"/> Alferon N | | <input type="checkbox"/> Intron A | | <input type="checkbox"/> Pegasys | |
| | | | | <input type="checkbox"/> Actimmune | |
| <input type="checkbox"/> Other, Please specify: | | | | | |
| Are there any contraindications to formulary medications? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If yes, please specify: | | | | <input type="checkbox"/> New request <input type="checkbox"/> Continuation of therapy request | |
| What medication(s) has member tried and failed for this diagnosis? | | | | | |
| Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No | | Diagnosis: | | ICD-10 Code: | |
| Directions for Use: | | Strength: | | Dosage Form: | |
| | | Quantity: | | Day Supply: | |
| | | | | Duration of Therapy/Use: | |
| Turn-Around Time for Review | | | | | |
| <input type="checkbox"/> Standard – (24 hours) | | <input type="checkbox"/> 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 | | | | | |
| <input type="checkbox"/> Chronic Hepatitis B | | | | | |
| Current lab reports to support the following: | | <input type="checkbox"/> ALT > 2 times Upper Limit of Normal | | <input type="checkbox"/> Detectable Hepatitis B Virus Deoxyribonucleic Acid level | |
| | | | | <input type="checkbox"/> Hepatitis B e-antigen positive | |
| | | | | <input type="checkbox"/> Hepatitis B e-antigen negative | |
| Is there evidence of compensated Liver disease? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Renewal Only: | | | | | |
| Is lab report supportive of Hepatitis B e-antigen positive? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | Is lab report supportive of Hepatitis B e-antigen negative? | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Follicular Non-Hodgkin's Lymphoma (Stage III/IV) | | | | | |
| Will requested medication be given in conjunction with anthracycline-containing combination chemotherapy? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS)-Related Kaposi's Sarcoma | | | | | |
| <input type="checkbox"/> Hairy-Cell Leukemia | | | | | |
| Did member have less than a complete response to cladribine or pentostatin? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Was there a relapse at < 2 years of demonstrating a complete response to cladribine OR pentostatin? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Renewal Only: | | | | | |
| Is there evidence of disease progression? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Chronic Granulomatous Disease | | | | | |

| | | | | |
|---|------------------------------|-----------------------------|--|--|
| <input type="checkbox"/> Renewal Only: | | | | |
| Has the number and/or severity of infections has decreased? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Malignant Osteopetrosis | | | | |
| <input type="checkbox"/> Renewal Only: | | | | |
| Is there evidence of disease progression? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Condylomata acuminata - Genital or Venereal Warts | | | | |
| Is requested medication for intra-lesional use? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are the lesions small and limited in number? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did member have a trial and failure with topical treatments (for example, imiquimod cream, podofilox)? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Was there a trial and failure with a surgical technique (for example, cryotherapy, laser surgery, electrodesiccation, surgical excision)? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Renewal Only: | | | | |
| Was there at least 3 months between treatments, unless there are signs of disease progression? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> 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.