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

Opioids
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			
Are there any contraindications to formulary medications? ☐ Yes ☐ No	☐ New request	☐ Continuation of therapy request	
If yes, please specify:			
Directions for Use:	Strength:	Dosage Form:	
	Quantity:	Day Supply:	Duration of Therapy/Use:
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes ☐ No ☐	What is the diagnosis?	IDC-10 Code: _____	
What medication(s) have been tried and failed for this diagnosis? Please specify:			
Turn-Around Time for Review			
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____		
Clinical Information			
Pain is due to ONE of the following:	☐ Active Cancer ☐ Sickle Cell Disease ☐ Palliative/End of life ☐ Hospice ☐ N/A		
Will member be on both an opioid and a benzodiazepine at same time? ☐ Yes ☐ No	Will Naloxone be provided/offered to member, member's family or caretaker? ☐ Yes ☐ No ☐ N/A		
Is request for an opioid naïve member?	☐ Yes ☐ No ☐ N/A		
Will member be exceeding 50 MME per day limit? (circle one): Yes ☐ No ☐	If answered yes, please explain rationale:		
Is request for an opioid tolerant member?	☐ Yes ☐ No ☐ N/A		
Will member exceed the 90 MME per day limit? (circle one): Yes ☐ No ☐	If answered yes, please explain rationale:		
Is member experiencing moderate to severe pain?	☐ Yes ☐ No	Is documentation provided along with rationale for use? ☐ Yes ☐ No	
Has provider checked the state's Prescription Monitoring Program/Prescription Drug Monitoring Program for any		☐ Yes ☐ No	

opioid over dosages, or dangerous combinations, and for prescriptions from other providers, benzodiazepine use, or extended release/long acting use for acute pain?		

Additional Clinical Information

Short Acting Opioids

Is request exceeding the 5-day supply limit?	☐ Yes	☐ No		
Was there a trial and failure with non-opioid analgesics? (for example, NSAIDs, acetaminophen, anticonvulsants, or antidepressants)	☐ Yes	☐ No	☐ N/A	
Is documentation provided with this request?	☐ Yes	☐ No		
Was there intolerance or contraindication to NON-opioid analgesics and documentation is provided with this request?	☐ Yes	☐ No	☐ N/A	
Is member maintained on more than 2 short acting opioids?	☐ Yes	☐ No		

Long Acting Opioids

Is request for oxymorphone ER?	☐ Yes	☐ No	If yes, was there inadequate response or intolerance to 2 formulary long-acting opioids for 2 weeks?	☐ Yes	☐ No	
Is request for non-formulary agent?	☐ Yes	☐ No	If yes, was there inadequate response or intolerance to oxymorphone ER AND 2 formulary long-acting opioids for 2 weeks?	☐ Yes	☐ No	
Is member currently on a Short Acting Opioid?	☐ Yes	☐ No	Is this a transition from one Long Acting Opioid to another?	☐ Yes	☐ No	
Are ANY of the following present? (circle one):	☐ Significant Respiratory Depression	☐ Acute or Severe Bronchial Asthma or Hypercarbia	☐ Known or Suspected Paralytic Ileus	☐ N/A		
Will the Long Acting Opioid be used as needed (PRN)?	☐ Yes	☐ No	Is member maintained on more than 2 long acting opioids?	☐ 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