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

Promacta
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				
What medication(s) has the member tried and failed for this diagnosis? Please specify:				
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No	Diagnosis:		ICD-10 Code:	
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes ☐ No		☐ New request	☐ Continuation of therapy request
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				
The following labs will be monitored at baseline AND regularly throughout therapy?	☐ Ocular examination	☐ LFTs	☐ Platelet count	☐ CBC with differentials

☐ **Chronic Immune Thrombocytopenia**						
Did member have insufficient response to corticosteroids, immunoglobulins, or splenectomy?					☐ Yes	☐ No
Will Promacta be used to prevent major bleeding in member with platelet count <30,000/mm3?	☐ Yes	☐ No	Is request to achieve platelet counts in the normal range (150,000-450,000/mm3)?		☐ Yes	☐ No

☐ **Renewals Only:**						
Was there a platelet increase to >50,000/mm3 to <200,000/mm3?	☐ Yes	☐ No	Was there no platelet increase to >50,000/mm3?		☐ Yes	☐ No

☐ **Hepatitis C-Associated Thrombocytopenia:**						
Does member have chronic hepatitis C with baseline thrombocytopenia (platelet count <75,000/mm3), which prevents initiation of interferon-based therapy, when interferon is required?					☐ Yes	☐ No

☐ **Renewals Only**						
Was there a platelet increase to >90,000/mm3?	☐ Yes	☐ No	Was there no platelet increase to >50,000/mm3?		☐ Yes	☐ No

☐ **Severe Aplastic Anemia**						
Bone marrow cellularity is <25% of at least 2 of the following:	☐ Absolute neutrophil count <500/mm3		☐ Platelet count < 20,000/mm3		☐ Absolute reticulocyte count <20,000/mm3	
Is anemia refractory to previous 1st line treatment, including hematopoietic cell transplantation OR immunosuppressive therapy with combination cyclosporine-A AND anti-thymocyte globulin?	☐ Yes	☐ No	Does member have platelet count <30,000/mm3?		☐ Yes	☐ No

☐ **Renewals Only:**						
Was there a platelet increase to >50,000/mm3?	☐ Yes	☐ No	Was there no platelet increase to >50,000/mm3?		☐ 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.