



**Medical Exception/
Prior Authorization/Precertification*
Request for Prescription Medications**

Fax this form to: 1-877-269-9916
OR

Submit your request online at:
<https://navinet.navimedix.com/Main.asp>
Visit www.aetna.com/formulary to access
our Pharmacy Clinical Policy Bulletins.

For FASTEST service, call 1-855-240-0535, Monday-Friday, 8 a.m. to 6 p.m. Central Time

Patient Information		Prescriber Information
Patient Name		Today's Date
Patient Insurance ID Number		Physician Name
Patient Address, City, State, ZIP		Physician Address
Home Telephone		M.D. Office Telephone Number
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient Date of Birth	M.D. Office Fax Number

Diagnosis and Medical Information			
Medication	Strength	Frequency	
Expected Length of Therapy	Quantity	Day Supply	If this is a continuation of therapy, how long has the patient been on the medication?

PLEASE CHECK ALL BOXES THAT APPLY:

Do you want a drug specific prior authorization criteria form faxed to your office? Yes No (If yes, no further questions are required).

- What condition is the drug being prescribed for? ICD code _____
Diagnosis _____
- Does the patient have a diagnosis of cancer? Yes No
- Please list all medications the patient has tried specific to the diagnosis and specify below:
Therapeutic failure, including length of therapy for each drug: _____
Drugs (s) contraindicated: _____
Adverse even (e.g., toxicity, allergy) for each drug: _____
- Is the request for a patient with one or more chronic conditions (e.g., psychiatric condition, diabetes) who is stable on the current drug(s) and who might be at high risk for a significant adverse event with a medication change? If so, specify anticipated significant adverse event:

- Has the condition been confirmed by diagnostic testing? If so, please provide diagnostic test and date:

- Does the patient have a clinical condition for which other alternatives are not recommended based on published guidelines or clinical literature? If so, please provide documentation: _____
- Does the patient require a specific dosage form (e.g., suspension, solution, injection)? If so, please provide dosage form:

- Are additional risk factors (e.g., GI risk, cardiovascular risk, age) present? If so, please provide risk factors: _____
- Other: Please provide additional relevant information: _____

REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION.
PLEASE COMPLETE CORRESPONDING SECTION ON BACK PAGE FOR THE SPECIFIC DRUG/CLASS LISTED BELOW.

Antifungals/Antiemetic (5-HT3) Agents/Celebrex/Erectile Dysfunction Agents/Proton Pump Inhibitors/Protopic
Provigil/Nuvigil/Stimulants/Tazorac/Tretinoin Products/Triptans

FOR ANY DRUG/CLASS NOT LISTED ON THE BACK PAGE, PLEASE ATTACH ADDITIONAL INFORMATION, BUT CANNOT EXCEED TWO PAGES

PRESCRIPTION BENEFIT PLAN MAY REQUEST ADDITIONAL INFORMATION OR CLARIFICATION, IF NEEDED, TO EVALUATE REQUESTS

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733.

Prescriber Signature	Date
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Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

PLEASE COMPLETE CORRESPONDING SECTION FOR THESE SPECIFIC DRUGS/CLASSES LISTED BELOW AND CIRCLE THE APPROPRIATE ANSWER OR SUPPLY RESPONSE.

ANTIFUNGALS: LAMISIL, SPORANOX, PENLAC, DIFLUCAN

Does the patient have secondary medical risk factors? Please specify which risk factor(s): _____

If the patient has a diagnosis of Onychomycosis, does the infection involve the toenails, fingernails or both? **Please circle**

If the diagnosis is Tinea corporis or Tinea cruris, does the patient require systemic therapy or have more extensive superficial infections? Yes No

ANTIEMETIC (5-HT3) AGENTS: (Ondansetron quantities of 12 or less per 30 days do not require a prior authorization)

Is the patient receiving moderate to highly emetogenic chemotherapy? Monthly frequency _____ Yes No

Is the patient receiving radiation therapy? Monthly frequency _____ Yes No

If the patient has a diagnosis of Hyperemesis Gravidarum, has the patient experienced an inadequate treatment response to two of the following medications?

vitamin B6, doxylamine, promethazine (Phenergan), trimethobenzamide (Tigan) or metoclopramide (Reglan)? Yes No

CELEBREX:

Is the patient at risk for a severe NSAID-related gastrointestinal (GI) adverse event (e.g., NSAID associated gastric ulcer, GI bleed)? Yes No

ERECTILE DYSFUNCTION: CIALIS, LEVITRA, VIAGRA, ALPROSTADIL

Does the patient require nitrate therapy on a regular OR on an intermittent basis, or is the patient currently taking another ED medication? Yes No

If a diagnosis of erectile dysfunction, is it due to neurogenic etiology, vasculogenic etiology, psychogenic etiology or mixed etiology? **Please circle.**

Is it being used for symptomatic Benign Prostatic Hyperplasia (BPH)? Yes No

PROTON PUMP INHIBITORS:

Does the patient have frequent and severe symptoms of GERD (e.g., heartburn, regurgitation)? Yes No

Does the patient have atypical symptoms or complications of GERD (e.g., dysphagia, hoarseness, erosive esophagitis)? Yes No

PROTOPIC:

Has the patient had a therapeutic failure of a topical corticosteroid? Yes No

PROVIGIL/NUVIGIL:

If the patient has a diagnosis of Obstructive Sleep Apnea, is the patient currently using a continuous positive airway pressure (CPAP) machine or other device? Yes No

STIMULANTS: AMPHETAMINES, METHYLPHENIDATES, STRATTERA

Is this a renewal of therapy? Yes No

TAZORAC/ TRETINOIN PRODUCTS:

Has the patient tried and failed products from the following categories: Salicylic Acid Products OR Benzoyl Peroxide products? Yes No

TRIPTANS:

Is the patient currently using migraine prophylactic therapy (e.g., amitriptyline, propranolol, timolol)? Yes No