



Medical Exception / Precertification* Request Form For Prescription Medications

**Fax to: 1-800-408-2386, call: 1-800-414-2386, or email: <https://www.aetna.com/provweb/>
Visit www.aetna.com/formulary to access the Pharmacy Coverage Policy Bulletins.
In order for us to process your request, ALL applicable fields MUST be filled in.**

Patient Name _____ Today's Date _____
 Patient Insurance ID # _____ Patient Date of Birth _____
 Physician Name (print) _____ Telephone () _____
 Physician Signature (REQUIRED) _____ Fax () _____

Please circle **Antihistamine** requested: ALLEGRA^{NF} ALLEGRA-D^{NF} CLARINEX^{NF} SEMPREX-D^{NF} ZYRTEC^{NF} ZYRTEC-D^{NF}
 Diagnosis (circle all that apply) Allergic Rhinitis Chronic Idiopathic Urticaria Other _____
 Previous therapy, including OTCs: _____ Dates (if available) _____
 Response to previous therapy (circle all that apply) Inadequate response Adverse effect(s) Comments _____

Please circle **Proton Pump Inhibitor** requested: ACIPHEX^F NEXIUM^{NF} PREVACID^F PRILOSEC^{NF} PROTONIX^{NF} omeprazole (generic)^{NF}
 Dosage requested _____ mg QD BID TID Other _____
 Diagnosis (circle all that apply) GERD Nocturnal acid breakthrough Barrett's esophagus Hypersecretory condition
 H. pylori eradication Other _____
 Previous therapy, with dates: _____
 Response to previous therapy (circle all that apply) Inadequate response Adverse effect(s) Comments _____

Please circle **COX-II Selective Inhibitor** requested: BEXTRA^{NF} CELEBREX^{NF} Dosage requested _____ mg QD BID
 Diagnosis (circle all that apply) Osteoarthritis Rheumatoid Arthritis Acute Pain Primary Dysmenorrhea
 Familial Adenomatous Polyposis (FAP) Other _____
 Previous therapy, with dates: _____
 Response to previous therapy (circle all that apply) Inadequate response Adverse effect(s) Comments _____
 Patient history of Peptic ulcer or NSAID-related ulcer/GI bleed? Yes No
 Patient using anticoagulants, antiplatelets, or corticosteroids? Yes No

Please circle **Antifungal** requested: DIFLUCAN^F fluconazole (generic)^F LAMISIL^F PENLAC^{NF} SPORANOX^{NF}
 Diagnosis (circle all that apply) Onychomycosis Tinea capitis, pedis, cruris, corporis Vulvovaginal Candidiasis
 Oral Candida (thrush) Candida (esophageal, intestinal, UTI, other) Other _____
 Previous therapy, with dates: _____
 Response to previous therapy (circle all that apply) Inadequate response Adverse effect(s) Comments _____

FOR ONYCHOMYCOSIS: KOH, PAS, fungal culture results: _____ Test Date: _____ Location: Fingernail(s) Toenail(s)
 Other existing conditions (circle all that apply) Pain Limiting Activity Diabetes Mellitus Systemic dermatosis
 Immunosuppression (AIDS, cancer, etc.) Peripheral vascular disease Other _____
 If prior onychomycosis therapy, please note: Drug: _____ Start Date: _____ Duration: _____
 Response to previous therapy (circle all that apply) Inadequate response Adverse effect(s) Comments: _____

Please circle **Antilipidemic** requested: ALTOCOR^{NF} CADUET^{NF} CRESTOR^{NF} LIPITOR^{NF} lovastatin (generic)^F
Formulary drugs = Lescol, Lescol XL, Zocor MEVACOR^{NF} PRAVACHOL^{NF} PRAVIGARD^{NF} VYTORIN^{NF} ZETIA^{NF}
 Dosage requested _____ mg Current LDL: _____ Target LDL: _____
 Current drug therapy with dose _____ or NONE (circle if applicable)
 Previous therapies received (please include duration and note if inadequate therapeutic response, adverse effects, or contraindicated in patient): _____

For ALL other precertification/medical exception requests
 Drug requested: _____ Duration of therapy: _____ Diagnosis: _____
 Previous therapies received (please include duration and note if inadequate therapeutic response, adverse effects, or contraindicated in patient): _____

For **Accutane/isotretinoin**: If female, pregnancy test results: _____ Test Date: _____

*The term precertification means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage. It does not mean precertification as defined by Texas law, as a reliable representation of payment of care or services to fully insured HMO and PPO member. **F=Formulary Drug; NF=Non-Formulary Drug**