Medical Exception/Precertification* Request Form for Prescription Medications

For *FASTEST* service, CALL 1-800-414-2386

Monday-Friday 8:00 am to 7:00 pm Central Time

Fax to: 1-800-408-2386 or email: https://www.aetna.com/provweb/

Visit www.aetna.com/formulary to access the Pharmacy Clinical Policy Bulletins

Patient Name_______________________________ Today's Date_______________________________

Patient Insurance ID #__________________________ Patient Date of Birth__________________________

MD Office Phone (_____)________________________ Physician Name (print)________________________

MD Office Fax (_____)__________________________ Physician Signature (**REQUIRED**)______________

ANTIHISTAMINE requested: **In order to process your request, ALL applicable fields MUST be completed**

☐ *fexofenadine (generic)* NP ☐ ALLEGRA NP ☐ ALLEGRA-D/ALLEGRA-D 24 HOUR NP ☐ CLARINEX NP
☐ CLARINEX-D/CLARINEX-D 24 HOUR NP ☐ SEMPREX-D NP ☐ ZYRTEC NP ☐ ZYRTEC-D NP

Dose requested _____ mg ☐ QD ☐ BID ☐ Other ______________ Additional Information________________

Diagnosis *(check all that apply)*
☐ Allergic rhinitis ☐ Chronic idiopathic urticaria ☐ Asthma ☐ Angioedema ☐ Other: ____________________

Previous therapy, including OTCs ______________________________ ☐ NONE Dates (*if available*) _____________

PROTON PUMP INHIBITOR requested: **In order to process your request, ALL applicable fields MUST be completed**

☐ PREVACID P ☐ NEXIUM P ☐ *omeprazole* P ☐ ACIPHEX NP ☐ PROTONIX NP ☐ PRILOSEC NP ☐ ZEGERID NP

Dosage requested ________ mg ☐ QD ☐ BID ☐ TID ☐ Other ____________________________

Diagnosis *(check all that apply)*
☐ GERD w/nocturnal acid breakthrough ☐ GERD ☐ Barrett's esophagus ☐ Hypersecretory condition
☐ H. pylori ☐ Laryngopharyngeal reflux ☐ Other ____

Previous therapy, including OTCs ______________________________ ☐ NONE Dates (*if available*) _____________
Additional Information____

ANTIFUNGAL requested: **In order to process your request, ALL applicable fields MUST be completed**

☐ LAMISIL P ☐ *fluconazole* (generic) P ☐ DIFLUCAN NP ☐ PENLAC NP ☐ SPORANOX NP ☐ VFEND NP

Diagnosis *(check all that apply)*
☐ Onychomycosis (***SEE BELOW***) ☐ (Circle) Tinea capitis / pedis / cruris / corporis ☐ Vulvovaginal candidiasis
☐ Oral candida (thrush) ☐ Other ____

Previous therapy, including OTCs ______________________________ ☐ NONE Dates (*if available*) _____________
Additional Information____

PLEASE COMPLETE FOR DIAGNOSIS: ONYCHOMYCOSIS
Fungal Lab Test Result: ☐ Positive ☐ Negative Test Date: ____________ Location: ☐ Fingernail(s) ☐ Toenail(s)

Other existing conditions *(check all that apply)*
☐ Pain-Limiting activity ☐ Diabetes mellitus ☐ Systemic dermatosis ☐ Immunosuppression (AIDS, cancer)
☐ Peripheral vascular disease ☐ Other ____

For ALL other requests: **In order to process your request, ALL applicable fields MUST be completed**
Drug requested:______________________ Duration of therapy:______________ Diagnosis: ___________________
Previous therapy, including OTCs ______________________________ ☐ NONE Dates (*if available*) _____________
For Additional Quantities Drug:__________________________ Strength(s): ___________________________
Provide the specific dosing schedule, including number of tablets per dose & number of doses per day:_________________
____

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 members.

P=Aetna Preferred Drug; **NP**=Aetna Non-Preferred Drug

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Patient Insurance ID #:______________________________ Patient Date of Birth:______________________________
MD Office Phone (_____): ______________________________ Physician Name (print): ______________________________
MD Office Fax (_____):______________________________ Physician Signature (**REQUIRED**):______________________________

HMG Co-A requested: **In order for us to process your request, ALL applicable fields MUST be completed**

☐ CRESTOR[P] ☐ VYTORIN[P] ☐ LESCOL/LESCOL XL[P] ☐ ADVICOR[P] ☐ LIPITOR[NP]
☐ PRAVACHOL[NP] ☐ MEVACOR[NP] ☐ ALTOPREV[NP] ☐ ZOCOR[NP] ☐ CADUET[NP]

Dose requested _____ **mg** Additional Information:______________________________

Diagnosis *(check all that apply)*:
☐ Hypercholesterolemia ☐ Mixed lipidemia ☐ Hyperlipidemia ☐ Other: ______________________________

Previous HMG therapy: ______________________________ Strength: ______________________________ ☐ NONE
Dates (*if available*): ______________________________

CNS STIMULANT requested: **In order for us to process your request, ALL applicable fields MUST be completed**

☐ ADDERALL XR[P] ☐ METADATE CD/[P] ☐ CONCERTA[NP] ☐ STRATTERA[NP] ☐ PROVIGIL[NP] ☐ RITALIN LA/SR[NP] ☐ DAYTRANA[P]

Diagnosis *(check all that apply)*:
☐ ADD ☐ ADHD ☐ Narcolepsy ☐ MS fatigue ☐ Idiopathic hypersomnia
☐ OSA (Obstructive Sleep Apnea) ☐ Other______________________________

Previous therapy: ______________________________ ☐ NONE
Dates (*if available*): ______________ Additional Information:______________________________

ANTIDEPRESSANT requested: **In order for us to process your request, ALL applicable fields MUST be completed**

☐ EFFEXOR XR[P] ☐ WELLBUTRIN XL[P] ☐ CYMBALTA[P] ☐ EFFEXOR[NP] ☐ PAXIL CR[NP]
☐ ZOLOFT[NP] ☐ LEXAPRO[NP] ☐ PROZAC WEEKLY[NP]

Diagnosis *(check all that apply)*:
☐ Major depressive disorder ☐ Generalized anxiety disorder (GAD) ☐ Social anxiety disorder (SAD)
☐ Perimenopausal hot flashes ☐ **DIABETIC** peripheral neuropathic pain ☐ Other ______________________________

Previous therapies – Please check brand or generic: ☐ **NONE**

☐ **Paxil CR**	**Paxil**	☐ Generic	☐ Brand	**Prozac**	☐ Generic	☐ Brand
☐ **Wellbutrin XL**	**Wellbutrin SR**	☐ Generic	☐ Brand	**Celexa**	☐ Generic	☐ Brand
☐ **Lexapro**	**Remeron**	☐ Generic	☐ Brand	**Desyrel**	☐ Generic	☐ Brand
	Luvox	☐ Generic	☐ Brand	**Zoloft**	☐ Generic	☐ Brand

Additional Information:______________________________

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Previous therapy, including OTCs ______________________________ ☐ NONE Dates (*if available*) ______________
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