Medical Exception/Precertification* Request for Prescription Medications

For FASTEST service, Call 1-800-414-2386
Monday-Friday, 8 a.m. to 7p.m., CT
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 Number:	Patient Date of Birth
M.D. Office Telephone Number	Physician Name (print)
M.D. Office Fax Number	Physician Signature **(Required)**

NON-SEDATING ANTIHISTAMINE REQUESTED – To process your request, **ALL** applicable fields **MUST** be completed.

Please note: The following products will not be covered when over-the-counter (OTC) equivalents are available:
All forms of *loratadine* (CLARITIN, CLARITIN D), *cetirizine* (ZYRTEC, ZYRTEC)

☐ CLARINEX[NP] ☐ CLARINEX-D[NP] ☐ SEMPREX-D[NP] ☐ XYZAL[NP]
☐ ALLEGRA[NP] ☐ ALLEGRA-D/ALLEGRA-D 24 HOUR[NP] ☐ *fexofenadine*[NP]

Dosage Requested:
_____ mg ☐ QD ☐ BID ☐ Other _____ Additional information _____

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

List ALL previous oral therapies (including OTCs): ☐ None Date(s) (if available) _____

_____

PROTON PUMP INHIBITOR REQUESTED – To process your request, **ALL** applicable fields **MUST** be completed.

☐ PREVACID[P] ☐ NEXIUM[P] ☐ *omeprazole*[P] ☐ *pantoprazole*[NP] ☐ ACIPHEX[NP] ☐ PRILOSEC[NP] ☐ ZEGERID[NP] ☐ PROTONIX[NP]

Dosage Requested:
_____ mg ☐ QD ☐ BID ☐ Other _____ Additional information _____

Diagnosis (check all that apply):
☐ GERD w/acid breakthrough – How close to a meal was the dose given? _____ min.
☐ GERD ☐ H. pylori ☐ GI bleed ☐ Barrett's esophagus ☐ Hypersecretory condition
☐ Laryngopharyngeal reflux ☐ Other _____

Previous therapy (including OTCs): ☐ None Date(s) (if available) _____

_____

Additional information _____

ANTIFUNGAL REQUESTED – To process your request, **ALL** applicable fields **MUST** be completed.

☐ *terbinafine*[P] ☐ *fluconazole*[P] ☐ *itraconazole*[P] ☐ *ciclopirox soln*[P] ☐ LAMISIL[NP] ☐ DIFLUCAN[NP] ☐ SPORANOX[NP] ☐ PENLAC[NP]

Diagnosis (check all that apply):
☐ Onychomycosis* (see below) ☐ Tinea (circle): capitis / pedis / cruris / corporis ☐ Other _____
☐ Oral candida (thrush) ☐ Vulvovaginal candidiasis (if recurrent, list number of episodes per year _____

Previous therapy (including OTCs): ☐ None Date(s) (if available) _____

_____

Additional information _____

Complete for Diagnosis: ONYCHOMYCOSIS
Fungal lab test results: ☐ 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 _____

OTHER REQUESTS – To process your request, **ALL** applicable fields **MUST** be completed.

Drug Name _____ Duration of therapy _____ Diagnosis _____

Previous therapy (including OTCs): ☐ None Date(s) (if available) _____

_____

For Additional quantities Drug _____ Strength _____

Provide the specific dosing schedule, including number of tablets per dose and number of doses per day _____

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= Non-preferred Drug

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HMG Co-A REQUESTED – To process your request, **ALL** applicable fields **MUST** be completed.

Please note: Generic preferred products include *simvastatin, lovastatin and pravastatin*

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

Dosage Requested:
_____ mg ☐ QD ☐ BID Additional information _____

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

Previous HMG therapy _____ Strength _____ ☐ None
Current HMG therapy _____ Strength _____ ☐ None
Dates (if available) _____

CNS STIMULANT REQUESTED – To process your request, **ALL** applicable fields **MUST** be completed.

Please note:Preferred products include *amphetamine/dextroamphetamine, dexmethylphenidate, methylin ER, methylphenidate/SR/CR,* ADDERALL XR, DAYTRANA, & VYVANSE

☐ STRATTERA[NP] ☐ CONCERTA[NP] ☐ DESOXYN[NP] ☐ METADATE ER[NP] ☐ METADATE CD[NP]
☐ FOCALIN/FOCALIN SR[NP] ☐ RITALIN LA/SR[NP] ☐ PROVIGIL[NP] ☐ OTHER _____

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 – To process your request, **ALL** applicable fields **MUST** be completed.

Please note: Generic preferred products include *sertraline, buproprion/SR/XL, citalopram, venlafaxine, paroxetine, fluoxetine, mirtazapine*

☐ EFFEXOR XR[P] ☐ CYMBALTA[P] ☐ PRISTIQ[P] ☐ PAXIL CR[NP] ☐ LEXAPRO[NP] ☐ PROZAC WKLY[NP] ☐ OTHER _____

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 – Check brand or generic where required:
☐ None ☐ CYMBALTA ☐ LEXAPRO ☐ EFFEXOR XR

PAXIL	☐ Generic	☐ Brand	PROZAC	☐ Generic	☐ Brand
WELLBUTRIN/SR/XL	☐ Generic	☐ Brand	CELEXA	☐ Generic	☐ Brand
EFFEXOR	☐ Generic	☐ Brand	ZOLOFT	☐ Generic	☐ Brand

REQUESTS FOR DRUGS WITH STEP THERAPY REQUIREMENTS – To process your request, **ALL** applicable fields **MUST** be completed.

Drug Name _____
Diagnosis _____ **Previous therapy** (including OTCs): _____ ☐ None
Response to previous therapy _____ Dates (if available) _____
Is there a contraindication to the step therapy alternatives? If yes, please describe _____

REQUESTS FOR ADDITIONAL QUANTITIES – To process your request, **ALL** applicable fields **MUST** be completed.

Drug Name and Strength _____ Diagnosis _____
Number of tablets requested _____ Previous therapy (including OTCs): _____ ☐ None
Provide the specific dosing schedule **including the number of tablets per dose and number of doses per day**
_____
Why is this dosing schedule required?_____

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