aetna™

Aetna Better Health®

Fax completed prior authorization request form to 877-309-8077 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/pennsylvania/providers/pharmacy

Opioids
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					
Preferred Long-Acting Opioid:	☐ Buprenorphine Patch	☐ Fentanyl Patch	☐ Methadone	☐ Morphine Sulfate Extended-Release Tablets	☐ Tramadol Extended-Release Tablets
Non-Preferred Long-Acting Opioid:	Specify drug:				
Short-Acting Opioid:	Specify drug:				
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:		
Medication request is NOT for an FDA-approved, or compendia-supported diagnosis (circle one): ☐Yes ☐No	Diagnosis:		ICD-10 Code:		
What medication(s) have been tried and failed for this diagnosis? Please specify:					
Turn-Around Time for Review					
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____				
Clinical Information					
☐ **Long-Acting Opioids**					
The requested drug is being prescribed due to ONE of the following:	☐ Cancer	☐ Sickle Cell Disease	☐ Terminal Condition	☐ Palliative/ End of life	☐ Hospice ☐ N/A
Is request for non-preferred product?	Yes ☐ No ☐	Was there inadequate response, intolerance, or contraindication to three formulary alternatives? **If yes, documentation needs to be submitted.**	☐ Yes	☐ No	☐ N/A
The requested drug is being prescribed for CHRONIC pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid?				☐ Yes	☐ No

Is the patient able to safely take the requested dose based on their history of opioid use?	☐ Yes	☐ No	The patient has been evaluated and will be monitored regularly for the development of opioid use disorder?	☐ Yes	☐ No
The patient's pain will be reassessed in the first month after the initial prescription or any dose increase AND every three months thereafter to ensure that clinically meaningful improvement and function outweigh risks to patient safety?				☐ Yes	☐ No
Is this request for a continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days?	☐ Yes	☐ No	Is this request for a patient who has taken an immediate-release opioid for at least one week?	☐ Yes	☐ No
Is this request for a methadone product and it is NOT being prescribed for detoxification treatment of as part of a maintenance treatment plan for opioid/substance abuse or addiction?				☐ Yes	☐ No

☐ **Short Acting Opioids**

The requested drug is being prescribed due to ONE of the following:	☐ Cancer	☐ Sickle Cell Disease	☐ Terminal Condition	☐ Palliative/ End of life	☐ Hospice	☐ N/A

Is request for non-preferred product?	Yes ☐	No ☐	Was there inadequate response, intolerance, or contraindication to the three formulary alternatives? **If yes, documentation needs to be submitted.**	☐ Yes	☐ No	☐ N/A

Is the patient able to safely take the requested dose based on their history of opioid use?	☐ Yes	☐ No	Is the patient 19 years of age or younger and has been evaluated and will be monitored regularly for the development of opioid use disorder?	☐ Yes	☐ No
The requested drug is being prescribed for moderate to CHRONIC pain where use of an opioid analgesic is appropriate?	☐ Yes	☐ No	The patient's pain will be reassessed in the first month after the initial prescription or any dose increase AND every three months thereafter to ensure that clinically meaningful improvement and function outweigh risks to patient safety?	☐ Yes	☐ No
Does the patient require extended treatment beyond 3 days for moderate to severe ACUTE pain where use of an opioid analgesics is appropriate?				☐ 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 to check the status of a request.
Pennsylvania CHIP:1-800-822-2447.