aetna™

Aetna Better Health®

Fax completed prior authorization request form to 855-296-0323 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/newjersey/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					
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:		IDC-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						
Pain is due to ONE of the following:	☐ Active Cancer	☐ Sickle Cell Disease	☐ Palliative/End of life	☐ Hospice	☐ N/A	
Will member be on both opioid AND BNZ?	☐ Yes	☐ No	Will Naloxone be provided/offered to member, member's family, or caretaker?	☐ Yes	☐ No	☐ N/A
Is request for an opioid naïve member?				☐ Yes	☐ No	
Will member be exceeding 50 MME per day limit? (circle one): ☐Yes ☐No	If answered yes, explain rationale:					
Is request for opioid tolerant member?				☐ Yes	☐ No	

Will member exceed the 90 MME per day limit? (circle one): ☐ Yes ☐ No			If answered yes, please explain rationale:			
Is member experiencing moderate to severe pain?	☐ Yes	☐ No	Is documentation provided along with rationale for use?		☐ Yes	☐ No
Additional Clinical Information						
☐ **Short Acting Opioid**						
Is request exceeding the 5-day supply limit?	☐ Yes	☐ No	Was there trial AND failure with non-opioid analgesics? (NSAIDs, APAP, anticonvulsants, OR antidepressants)		☐ Yes	☐ No
Is member maintained on more than 2 short acting opioids?	☐ Yes	☐ No	Was there intolerance OR contraindication to NON-opioid analgesics?		☐ Yes	☐ No
☐ **Long-Acting Opioid**						
Is request for oxymorphone ER?	☐ Yes	☐ No	If yes, was there inadequate response OR intolerance to 2 formulary LA opioids for 2 weeks?		☐ Yes	☐ No
Is request for buprenorphine weekly patch?	☐ Yes	☐ No	If yes, Is there a need for opioid with lower risk for abuse AND noted concern that member OR member's household is at risk for abuse AND diversion?		☐ Yes	☐ No
Is request for non-formulary agent?	☐ Yes	☐ No	If yes, was there inadequate response or intolerance to oxymorphone ER AND 2 formulary long-acting opioids for 2 weeks?		☐ Yes	☐ No
Is request for abuse-deterrent product?	☐ Yes	☐ No	If yes, is there trial and failure of buprenorphine patch for at least 2 weeks?		☐ Yes	☐ No
			If yes, is there a need for abuse of deterrent product AND concern that member OR member's household is at risk?		☐ Yes	☐ No
Is member currently on a SA Opioid?	☐ Yes	☐ No	Is this a transition from one LA Opioid to another?		☐ Yes	☐ No
ANY of the following are present? (check that apply):	☐ Significant Respiratory Depression	☐ Acute or Severe Bronchial Asthma or Hypercarbia	☐ Known or Suspected Paralytic Ileus	☐ N/A		
Will LA Opioid be used as needed?	☐ Yes	☐ No	Is member maintained on >2 LA opioids?		☐ Yes	☐ No
☐ **Acute Pain in Pediatric Members <18 Years of Age**						
Is request for acute pain (post-dental procedure?	☐ Yes	☐ No	Was pain assessment completed?		☐ Yes	☐ No
Was member AND their parent/guardian screened for previous AND current opioid use?					☐ Yes	☐ No
Was concomitant use with BNZ appropriately addressed if present?	☐ Yes	☐ No	☐ N/A			
Was COMBO therapy with APAP and NSAIDs tried AND failed OR contraindications are present for use of both?					☐ Yes	☐ No
Will opioid be USED in COMBO with APAP and NSAIDs, unless contraindications are present for use of both?					☐ Yes	☐ No
Is request for codeine OR tramadol?	☐ Yes	☐ No	Will prescription be limited to 8 – 12 tablets?		☐ Yes	☐ No
Will IR opioids be prescribed at limited to lowest effective dose AND no quantity greater than expected pain duration to require opioids will be given (NOTE: ≤3 days is recommended by CDC. >7 days will rarely be required)					☐ 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 855-232-3596 to check the status of a request.