Aetna Better Health®

Fax completed prior authorization request form to 855-799-2551 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/michigan/providers/medicaid/pharmacy

Emflaza
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				
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:	
Renewal Requests Only: Is there documentation the member is receiving clinical benefit from therapy such as improvement or stabilization of muscle strength or pulmonary function? If yes, please specify below.	☐ Yes	☐ No		
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		
Has the member experienced a severe behavioral adverse effect while on prednisone therapy that has or would require a prednisone dose reduction? If yes, please specify below.	☐ Yes	☐ No
Has the member tried prednisone for greater than 6 months and had at least one of the following significant intolerable adverse effects that is unable to be managed (check all that apply):	☐ Central (truncal) obesity ☐ Weight gain of at least 10% of body weight over 6-month period ☐ Diabetes and/or hypertension that is difficult to manage	
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records		

Proprietary

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 855-300-5528 to check the status of a request.

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