



Medical Exception/Precertification*
Request for Prescription Medications
 For FASTEST service, call 1-800-414-2386
 Monday-Friday, 8 a.m. to 7 p.m. Central Time

Fax this form to: 1-800-408-2386 OR
 Submit your request online at:
<https://navinet.navimedix.com/Main.asp>
 Visit www.aetna.com/formulary to access
 our 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)
Office contact for questions or clarifications:	Office Contact Telephone Number (include extension)

NON-SEDATING ANTIHISTAMINE - To process your request, ALL fields MUST be completed
 Please note: loratadine (CLARITIN/CLARITIN D) & cetirizine (ZYRTEC/ZYRTEC D) will not be covered - an over-the-counter (OTC) equivalent is available

CLARINEX^{NP} CLARINEX-D^{NP} SEMPREX-D^{NP} XYZAL^{NP}
 ALLEGRA^{NP} ALLEGRA-D/ALLEGRA-D 24 HOUR^{NP} fexofenadine^{NP}

Dose 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 OTC's): None Date(s) (if available) _____

PROTON PUMP INHIBITOR - To process your request, ALL fields MUST be completed
 Please note: On some plans omeprazole (PRIOSEC) 20 mg & Prevacid 15 mg will not be covered - over-the-counter (OTC) equivalents are available

KAPIDEX^P NEXIUM^P lansoprazole^P omeprazole^P pantoprazole^{NP}
 ZEGERID^{NP} ACIPHEX^{NP} PREVACID^{NP} PRIOSEC^{NP} PROTONIX^{NP}

Dose Requested: _____ mg QD BID Other _____

Diagnosis (check all that apply):
 GERD w/acid breakthrough (please complete additional 2 questions below)
 How close to a meal was the dose given? _____ min. Has member tried 4 wks of once daily PPI therapy? Yes No
 GERD H. pylori GI bleed Barrett's esophagus Hypersecretory condition
 Laryngopharyngeal reflux Ulcer (specify type) _____ Other _____

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

Additional information _____

ORAL & TOPICAL ANTIFUNGAL – To process your request, ALL fields MUST be completed

terbinafine^P fluconazole^P itraconazole^P ciclopirox soln^P LAMISIL^{NP} DIFLUCAN^{NP*} SPORANOX^{NP} PENLAC^{NP}

*For fluconazole, provide strength, number of tablets per dose & number of doses per day: _____

Diagnosis: Onychomycosis **Complete this section ONLY 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 _____

All Other Diagnosis (check all that apply):
 Onychomycosis* (see above) Tinea (circle): capitis / pedis / cruris / corporis Other _____
 Oral candida (thrush) Vulvovaginal candidiasis (if recurrent, list dates in previous 12 months _____)

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

Additional information _____

OTHER REQUESTS – To process your request, ALL 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 _____

For isotretinoin products (All brands and generics) – Is the patient enrolled in the iPledge program? _____



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Patient Insurance ID Number:	Patient Date of Birth
M.D. Office Telephone Number	Physician Name (print)
M.D. Office Fax Number	Physician Signature (Required)
Office contact (who can we contact at your office if we have a question):	Office Contact Telephone Number (include extension)

HMG Co-A - To process your request, ALL fields MUST be completed

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

- | | | | | | |
|--|--|--|--|---|---|
| <input type="checkbox"/> CRESTOR ^P | <input type="checkbox"/> VYTORIN ^P | <input type="checkbox"/> LESCOL/LESCOL XL ^P | <input type="checkbox"/> ADVICOR ^P | <input type="checkbox"/> ZETIA ^P | <input type="checkbox"/> SIMCOR ^P |
| <input type="checkbox"/> PRAVACHOL ^{NP} | <input type="checkbox"/> MEVACOR ^{NP} | <input type="checkbox"/> ZOCOR ^{NP} | <input type="checkbox"/> LIPITOR ^{NP} | <input type="checkbox"/> CADUET ^{NP} | <input type="checkbox"/> ALTOPREV ^{NP} |

Dosage Requested: _____ mg QD BID Additional information _____

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

Previous HMG and/or fenofibrate therapy _____ Strength _____ None
Current HMG and/or fenofibrate therapy _____ Strength _____ None

Does the patient have a contraindication, intolerance, or allergy to any preferred alternatives or previous therapies? Please describe: _____

CNS STIMULANT - To process your request, ALL fields MUST be completed

Preferred products include *amphetamine/dextroamphetamine, dexamethylphenidate, dextroamphetamine, methylin/ER, methylphenidate/SR, VYVANSE*

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> STRATTERA ^{NP*} | <input type="checkbox"/> CONCERTA ^{NP} | <input type="checkbox"/> DESOXYN ^{NP} | <input type="checkbox"/> RITALIN LA/SR ^{NP} | <input type="checkbox"/> FOCALIN/FOCALIN XR ^{NP} |
| <input type="checkbox"/> METADATE CD ^{NP} | <input type="checkbox"/> ADDERALL XR ^{NP} | <input type="checkbox"/> NUVIGIL ^{P*} | <input type="checkbox"/> PROVIGIL ^{NP*} | <input type="checkbox"/> OTHER _____ |

*FOR STRATTERA/NUVIGIL/PROVIGIL: Does patient have: Anxiety Tourette's Seizure DO At risk of/history of drug abuse

Diagnosis (check all that apply):
 ADD ADHD Narcolepsy MS fatigue Idiopathic hypersomnia OSA/HS Other _____

Previous therapy _____ None Dates (if available) _____
 Current therapy _____ None Date treatment began: _____

ANTIDEPRESSANTS - To process your request, ALL fields MUST be completed

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

- | | | | | | | |
|--|--|---|---|--|---|--------------------------------------|
| <input type="checkbox"/> EFFEXOR XR ^P | <input type="checkbox"/> CYMBALTA ^P | <input type="checkbox"/> PRISTIQ ^P | <input type="checkbox"/> PAXIL CR ^{NP} | <input type="checkbox"/> LEXAPRO ^{NP} | <input type="checkbox"/> VENLAFAXINE ER ^{NP} | <input type="checkbox"/> OTHER _____ |
|--|--|---|---|--|---|--------------------------------------|

Diagnosis (check all that apply):
 Major depressive disorder (MDD) Anxiety disorder (Specify type) _____ Perimenopausal hot flashes
 DIABETIC peripheral neuropathic pain PMDD Other _____

Current therapy _____ None Date treatment began: _____

PREVIOUS therapies – Check brand or generic where required: None OTHER _____

PAXIL	<input type="checkbox"/> Generic <input type="checkbox"/> Brand	PROZAC	<input type="checkbox"/> Generic <input type="checkbox"/> Brand	EFFEXOR XR	<input type="checkbox"/>
WELLBUTRIN/SR/XL	<input type="checkbox"/> Generic <input type="checkbox"/> Brand	CELEXA	<input type="checkbox"/> Generic <input type="checkbox"/> Brand	CYMBALTA	<input type="checkbox"/>
EFFEXOR	<input type="checkbox"/> Generic <input type="checkbox"/> Brand	ZOLOFT	<input type="checkbox"/> Generic <input type="checkbox"/> Brand	LEXAPRO	<input type="checkbox"/>

REQUESTS FOR DRUGS (NOT LISTED ON THIS FORM) WITH STEP THERAPY REQUIREMENTS

To process your request, ALL 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 (TABLETS or DOSES PER DAY)

To process your request, ALL fields MUST be completed

Drug Name and Strength _____ Diagnosis _____
 Number of tablets requested (per month) _____ 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? _____

*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.