Aetna™

Medical Exception / Precertification Request Form
For Prescription Medications

Please complete form and fax to: 1-800-408-2386 or call 1-800-414-2386
Visit https://www.aetna.com/providerehealthoffice/ to register for a faster online response

Patient Name	Today's Date
Patient Insurance ID #	Patient Date of Birth
Physician Name (print)	Telephone ( )
Physician Signature (REQUIRED)	Fax ( )

Antihistamines requiring precert (Allegra/Allegra-D, Clarinex, Zyrtec/Zyrtec-D): (*circle your response*)

What drug is being requested? ALLEGRA ALLEGRA-D CLARINEX ZYRTEC ZYRTEC-D

What is the patient's diagnosis? *(circle all that apply)* Allergic Rhinitis Chronic Idiopathic Urticaria Other _____

List previous therapy, including OTCs: _____ Dates (*if available*) _____

Cox-2 inhibitors (Bextra, Celebrex, Vioxx): ***(please circle your response)***

What drug is being requested? BEXTRA CELEBREX VIOXX

What dosage is being requested? _____mg QD BID

What is the patient's diagnosis? *(circle all that apply)* Osteoarthritis Rheumatoid Arthritis Acute Pain
Primary Dysmenorrhea Familial Adenomatous Polyposis (FAP) Other _____

List previous therapy, with dates: _____

Is the patient age 18 years or greater? Yes No

Does the patient have a history of peptic ulcer disease or NSAID-related ulcer/GI bleeding? Yes No

Is the patient currently using anticoagulants, antiplatelets, or corticosteroids? Yes No

Antifungals (Diflucan, Lamisil, Penlac, Sporanox) ***(please circle your response)***

What drug is being requested? DIFLUCAN LAMISIL PENLAC SPORANOX

What is the patient's diagnosis? *(circle all that apply)* Onychomycosis Vulvovaginal Candidiasis
Tinea capitis, pedis, cruris, corporis Oral Candida (thrush)
Candida (esophageal, intestinal, UTI, other) Other _____

List previous therapy, with dates: _____

FOR ONYCHOMYCOSIS:

KOH, PAS, fungal culture results: _____ Test Date: _____

Location? Fingernail(s) Toenail(s)

What other conditions does patient have? *(circle all that apply)* Pain Limiting Activity Diabetes Mellitus
Immunosuppression (AIDS, cancer, etc.) Systemic dermatosis
Peripheral vascular disease Other _____

If prior onychomycosis therapy, please note: Drug: _____ Start Date: _____ Duration: _____

Accutane, isotretinoin

What is the patient's diagnosis? _____

Previous therapy: *(circle all that apply)* doxycycline minocycline Other _____

If female, pregnancy test results: _____ Test Date: _____

For ALL other precertification/medical exception requests:

Drug requested: _____ Duration of therapy requested: _____

Diagnosis: _____

Previous therapy received: _____ _____ _____ _____

Duration of previous therapy: _____ _____ _____ _____