



## 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/provweb/> to register to e-mail your requests for a faster response.  
 Visit [www.aetna.com/formulary](http://www.aetna.com/formulary) to access the Pharmacy Coverage Policy Bulletins.

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

Please circle **Antihistamine** requested: ALLEGRA ALLEGRA-D CLARINEX SEMPRES-D 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) \_\_\_\_\_

Response to previous therapy (circle all that apply) Inadequate response Adverse effect(s) Comments \_\_\_\_\_

Please circle **Proton Pump Inhibitor** requested: ACIPHEX NEXIUM PREVACID PRILOSEC PROTONIX omeprazole (generic)

What dosage is being requested? \_\_\_\_\_ mg QD BID TID Other \_\_\_\_\_

What is the patient's diagnosis? (circle all that apply) GERD Nocturnal acid breakthrough Barrett esophagus Hypersecretory condition  
 H. pylori eradication Other \_\_\_\_\_

List previous therapy, with dates: \_\_\_\_\_

Response to previous therapy (circle all that apply) Inadequate response Adverse effect(s) Comments \_\_\_\_\_

Please circle **COX-II Selective Inhibitor** 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: \_\_\_\_\_

Response to previous therapy (circle all that apply) Inadequate response Adverse effect(s) Comments \_\_\_\_\_

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

Please circle **Antifungal** requested: DIFLUCAN LAMISIL PENLAC SPORANOX

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

List previous therapy, with dates: \_\_\_\_\_

Response to previous therapy (circle all that apply) Inadequate response Adverse effect(s) Comments \_\_\_\_\_

**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: \_\_\_\_\_

Response to previous therapy (circle all that apply) Inadequate response Adverse effect(s) Comments \_\_\_\_\_

**Accutane, isotretinoin**

What is the patient's diagnosis? \_\_\_\_\_

P revious therapy: (circle all that apply) doxycycline minocycline Other \_\_\_\_\_

Response to previous therapy (circle all that apply) Inadequate response Adverse effect(s) Comments \_\_\_\_\_

If female, pregnancy test results: \_\_\_\_\_ Test Date: \_\_\_\_\_

**For ALL other precertification/medical exception requests**

Drug requested: \_\_\_\_\_ Duration of therapy requested: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Previous therapy(ies) received, with duration: \_\_\_\_\_

Previous therapy(ies) with inadequate therapeutic response \_\_\_\_\_

Previous therapy(ies) causing adverse effects \_\_\_\_\_

Therapy(ies) contraindicated in patient \_\_\_\_\_

\*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 member.