Submit your request Online: www.Availity.com

Non-Specialty Drug Prior Authorization
Fax: 1-877-269-9916

Specialty Drug Prior Authorization
Fax: 1-866-249-6155

For FASTEST service, call 1-855-240-0535
Monday-Friday, 8 a.m. to 6 p.m. Central Time

Texas Standard Prior Authorization Request Form for Prescription Drug Benefits

Visit www.aetna.com/health-care-professionals.html to access our Pharmacy Clinical Policy Bulletins

Please read all instructions below before completing this form.

Please send this request to the issuer from whom you are seeking authorization. ***Do not send this form*** to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.

Consistent with TDI rule 28 TAC Section 19.1820, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Prescription Drug Benefits if the plan requires prior authorization of a prescription drug or device.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: Use this form to request authorization **by fax or mail** when an issuer requires prior authorization of a prescription drug, a prescription device, formulary exceptions, quantity limit overrides, or step-therapy requirement exceptions. An issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a prescription drug benefit.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; and 5) ask whether a prescription drug or device requires prior authorization; or 6) request prior authorization of a health care service.

Additional Information and Instructions:

Section I – Submission:

Enter the name and contact information for the issuer or the issuer's agent that manages or administers the issuer's prescription drug benefits, as applicable. An issuer or agent may have already prepopulated its contact information on the copy of this form posted on its website.

Section VI – Prescription Compound Drug Information:

List the quantities of ingredients in units of measure (mg, ml, etc.).

Section VIII – Patient Clinical Information:

Enter current ICD version.

Section IX – Justification:

In the space provided or on a separate page:

- Provide pertinent clinical information to justify requests for initial or ongoing therapy, or increases in current dosage, strength, or frequency.
- Explain any comorbid conditions and contraindications for formulary drugs.
- Provide details regarding titration regimen or oncology staging, if applicable.
- Provide pertinent information about any step-therapy exception, if applicable. Read Texas Insurance Code Section 1369.0546(c) online.

Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

Note: Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.

aetna® TDI | Texas Department of Insurance

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Section I – Submission

Submitted to:	Phone:	Fax:	Date:

Section II – Review

☐ **Expedited/Urgent Review Requested:** By checking this box and signing and dating below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee:______________________________Date:__________

Section III – Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown	
Address:	City:		State:	ZIP Code:
Issuer Name (if different from Section I):	Member or Medicaid ID #:	Group #:		

Section IV – Prescriber Information

Name:		NPI #:	Specialty:	
Address:		City:	State:	ZIP Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:	

Section V – Prescription Drug Information

(If this is a compound drug, identify all ingredients in Section VI, below.)

Requested Drug Name:				
Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:
☐ New therapy ☐ Continuation of therapy (approximate date therapy initiated: ______________________________

For continuation of therapy, complete the following to the best of your knowledge:
☐ Patient is adhering to the drug therapy regimen.
☐ The drug therapy regimen is effective.

Note: For a request for prior authorization of continuation of therapy (other than a request for a step-therapy exception as provided in 28 TAC Section 19.1820(a)(13)(B)), it is not necessary to complete Sections VIII or IX unless there has been a material change in the information previously provided. Section IX must be completed for a request for a step-therapy exception.

For Provider Administered Drugs Only:
HCPCS Code:____________________NDC #:____________________Dose Per Administration:____________________

Section VI – Prescription Compound Drug Information

Compound Drug Name:					
Ingredient	NDC #	Quantity	Ingredient	NDC #	Quantity

Section VII – Prescription Device Information

Requested Device Name:	Expected Duration of Use:	HCPCS Code (If applicable):

Section VIII – Patient Clinical Information

Patient's diagnosis related to this request:	ICD Version:	ICD Code:

(Provide the following information to the best of your knowledge)

Drugs patient has taken for this diagnosis:

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

Section IX – Justification (See the "Additional Information and Instructions" section)

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512
(CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Multi-language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104** (TTY: **711**).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104** (TTY: **711**).

VIETNAMESE: CHÚ Ý: nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104** (TTY: **711**).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104** (TTY: **711**)。

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로나 **1-800-385-4104** (TTY: **711**) 번으로 연락해 주십시오.

ARABIC: ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو عل **1-800-385-4104** (للصم والبكم: **711**).

URDU: توجہ دیں: اگر آپ اردو زبان بولتے ہیں، تو زبان سے متعلق مدد کی خدمات آپ کے لئے مفت دستیاب ہیں - اپنے شناختی کارڈ کے پیچھے موجود نمبر پر یا **1-800-385-4104** (TTY: **711**) پر رابطہ کریں-

TAGALOG: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104** (TTY: **711**).

FRENCH: ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro indiqué au verso de votre carte d'identité ou le **1-800-385-4104** (ATS: **711**).

HINDI: ध्यान दें: यदि आप हिंदी भाषा बोलते हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। अपने आईडी कार्ड के पृष्ठ भाग में दिए गए नम्बर अथवा **1-800-385-4104** (TTY: **711**) पर कॉल करें।

PERSIAN: اگر به زبان فارسی صحبت می کنید، به صورت رایگان می توانید به خدمات کمک زبانی دسترسی داشته باشید. با شماره درج شده در پشت کارت شناسایی یا با شماره **1-800-385-4104** (TTY: **711**) تماس بگیرید.

GERMAN: ACHTUNG: Wenn Sie deutschen sprechen, können Sie unseren kostenlosen Sprachservice nutzen. Rufen Sie die Nummer auf der Rückseite Ihrer ID-Karte oder **1-800-385-4104** (TTY: **711**) an.

GUJARATI: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડની પાછળ આપેલા નંબર પર અથવા **1-800-385-4104** પર કૉલ કરો (TTY: **711**).

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатне услуги перевода. Позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки, или по номеру **1-800-385-4104** (TTY: **711**).

JAPANESE: 注意事項:日本語をお話になる方は、無料で言語サポートのサービスをご利用いただけます。IDカード裏面の電話番号、または**1-800-385-4104** (TTY: **711**)までご連絡ください。

LAOTIAN: ເຊີນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຫາເບີໂທທີ່ຢູ່ດ້ານຫຼັງບັດປະຈຳຕົວຂອງທ່ານ ຫຼື **1-800-385-4104** (TTY: **711**).

TX-16-09-04