PHARMACY SERVICES
Aetna Public Employees Plan
Prior Authorization (PA) Request Form
PHONE (888) 361-1612
FAX (800) 207-8235

DATE: _____ **SENDER'S INITIALS:** _____

PATIENT INFORMATION

ENROLLEE NAME: _____ **DATE OF BIRTH:** _____

SUBSCRIBER ID #: _____

PHYSICIAN INFORMATION

NAME: _____

PHONE: _____ **FAX:** _____

CONTACT NAME: _____

MEDICATION INFORMATION

MEDICATION: _____

STRENGTH: _____ **FREQUENCY:** _____

ICD-9 CODE: _____

PREVIOUS MEDICATIONS TRIED, INCLUDING DOSE AND DURATION OF TRIAL: _____

CIRCUMSTANCES FOR MEDICAL NECESSITY: _____

Prior Authorization (PA) Request Form (continued)

ADDITIONAL QUESTIONS