



Fax this form to: 1-877-269-9916  
 For specialty drugs fax to: 1-888-267-3277  
 Aetna Specialty Pharmacy phone: 1-866-503-0857  
 OR

Submit your request online at:  
<https://navinet.navimedix.com/Main.asp>

## PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

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

<input type="checkbox"/> Urgent <sup>1</sup>		<input type="checkbox"/> Non-Urgent	
Requested Drug Name:			
<b>Patient Information:</b>		<b>Prescribing Provider Information:</b>	
Patient Name:		Prescriber Name:	
Member/Subscriber Number:		Prescriber Fax:	
Policy/Group Number:		Prescriber Phone:	
Patient Date of Birth (MM/DD/YYYY):		Prescriber Pager:	
Patient Address:		Prescriber Address:	
Patient Phone:		Prescriber Office Contact:	
Patient Email Address:		Prescriber NPI:	
		Prescriber DEA:	
Prescription Date:		Prescriber Tax ID:	
		Specialty/Facility Name (If Applicable):	
		Prescriber Email Address:	
<b>Prior Authorization Request for Drug Benefit:</b>		<input type="checkbox"/> New Request <input type="checkbox"/> Reauthorization	
Patient Diagnosis and ICD Diagnostic Codes(s):			
Drug(s) Requested (with J-Code, if applicable):			
Strength/Route/Frequency:			
Unit/Volume of Named Drug(s):			
Start Date and Length of Therapy:			
Location of Treatment (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:			
Clinical Criteria for Approval, Including other Pertinent Information to Support the Request, other Medications Tried, Their Name(s), Duration, and Patient Response:			
Any additional information we should consider (please attach all supporting documents).			
For use in clinical trial? (if yes, provide trial name and registration number):			
Drug Name (Brand Name and Scientific Name)/Strength:			
Dose:		Route:	Frequency:
Quantity:		Number of Refills:	
Product will be delivered to:	<input type="checkbox"/> Patient's Home	<input type="checkbox"/> Physician Office	<input type="checkbox"/> Other:
Prescriber or Authorized Signature:			Date:
Dispensing Pharmacy Name and Phone Number:			
<input type="checkbox"/> Approved		<input type="checkbox"/> Denied	
If denied, provide reason for denial, and include other potential alternative medications, if applicable, that are found in the formulary of the carrier.			

1. A request for prior authorization that if determined in the time allowed for non-urgent requests could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request.