



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

DME/Medical Device Precertification Fax: 1-833-596-0339

For FASTEST service, call 1-888-632-3862, Monday-Friday, 8 a.m. to 6 p.m. Central Time

ARIZONA STANDARDIZED PRIOR AUTHORIZATION REQUEST FOR MEDICATION, DME, AND MEDICAL DEVICE

SECTION I – SUBMISSION

Subscriber Name:	Phone:	Fax:	Date:
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SECTION II – REASON FOR REQUEST

Check one:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Continuation/Renewal Request
Reason for request: (check all that apply)		<input type="checkbox"/> Prior Authorization
<input type="checkbox"/> Step Therapy, Formulary Exception		<input type="checkbox"/> Medical Device
<input type="checkbox"/> Quantity Exception		<input type="checkbox"/> Durable Medical Equipment (DME)
<input type="checkbox"/> Specialty Drug		<input type="checkbox"/> Other (please specify) _____

SECTION III – REVIEW

Expedited/Urgent Review Requested: By checking this box and signing 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: _____

SECTION IV – PATIENT INFORMATION

Name:	Phone:	DOB:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address:	City:	State:	ZIP Code:	
Subscriber Name (if different from Section I):	Member ID #:	Group Name or Number:		
BIN # (if available):	PCN (if available):	Rx ID # (if available):		

SECTION V – PRESCRIBER/ORDERING PROVIDER INFORMATION

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

SECTION VI – 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:				
<input type="checkbox"/> New therapy <input type="checkbox"/> Continuation of therapy (approximate date therapy initiated: _____)				
For Provider Administered Drugs Only:				
HCPCS Code: _____ NDC #: _____ Dose Per Administration: _____				

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SECTION VII — PRESCRIPTION COMPOUND DRUG INFORMATION

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

SECTION VIII — PRESCRIPTION DME or MEDICAL DEVICE INFORMATION

Requested DME or Medical Device Name:	Expected Duration of Use:	HCPCS Code (If applicable):
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SECTION IX — PATIENT CLINICAL INFORMATION

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

Drugs patient has taken for this diagnosis: *(Provide the following information to the best of your knowledge)*

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

Date	Test	Value

SECTION X — JUSTIFICATION (Provide or attach any additional justification here: Notes, Treatment plans, lab/test results, etc)

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.

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**).

NAVAJO: Díí BAA AKÓNÍNÍZIN: Díí bee yániłt'igo, saad bee áká'ánída'awo'déé', t'áá jiiik'eh, éí ná hóló. Ninaaltsoos nitł'izí bee nééhozinígíí bine'déé' béesh bee hane'í biká'ígíí bee hodíilnih doodago **1-800-385-4104** (TTY: **711**) hólne' dooleeł.

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**)。

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**).

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

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**).

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

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**).

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.

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные 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。

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.

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

SERBO-CROATIAN: OBAVEŠTENJE: Ako govorite srpski, usluge jezičke pomoći dostupne su vam besplatno. Pozovite broj na poleđini vaše identifikacione kartice ili broj **1-800-385-4104** (TTY – telefon za osobe sa oštećenim govorom ili sluhom: **711**).

THAI: ข้อควรระวัง: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรติดต่อหมายเลขที่อยู่ด้านหลังบัตร ID ของคุณ หรือหมายเลข **1-800-385-4104** (TTY: **711**)

AZ-16-09-03