aetna®

CRTR

2024 Tier Exception (cost-share reduction) Request

Page 1 of 2

(You must complete both pages.)

Please Note:
This form is intended for prescriber use to request a Tier Exception to reduce the cost-share of a medication. A prescriber supporting statement is required for Tier Exception requests. If a drug has prior authorization (PA) or Utilization Management (UM) requirements, then the PA or UM requirements must be satisfied before a Tier Exception request can be reviewed. Provide all supporting clinical information for PA and UM requirements as well as Tier Exception requirements, if applicable. Additionally, non-formulary and specialty drugs are not eligible for tier exceptions.

Fax completed form to: 1-800-408-2386 **For urgent requests, please call: 1-800-414-2386**

Patient information		**Prescriber information**	
Patient name		Today's date	Physician specialty
Patient insurance ID number		Physician name	NPI/DEA number
Patient address, city, state, ZIP		Physician address, city, state, ZIP	
Patient home telephone number		M.D. office telephone number	
Gender ☐ Male ☐ Female	Patient date of birth	M.D. office fax number	

Diagnosis and medical information		
Medication requested	Strength and route of administration	Frequency
Diagnosis *(Please include all office notes supporting diagnosis.)*		

Please check all boxes that apply:

1. ☐ **I have verified the formulary alternatives on the member's formulary and all covered Part D drugs on any tier of the Plan's formulary would not be as effective for the enrollee as the requested formulary drug and/or would be likely to cause adverse effects for the enrollee.**

2. ☐ **List drugs that are on a lower formulary tier that this patient has tried for their condition, including the formulary generic equivalent, if pertinent. CLINICAL INFORMATION IS REQUIRED about past effectiveness or side effects of the formulary alternative(s) for this patient.**

CURRENT/PAST MEDICATIONS USED	DATES OF TREATMENT	THERAPEUTIC OUTCOME

(continued on page 2)

Please check all boxes that apply *(continued)*:

3. ☐ **Other supporting information**

Note: Tier exception requests require prescriber supporting statements. Please attach supporting information for your request.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733. By signing this form, I represent that I have obtained patient consent as required under applicable state and federal law, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and state re-disclosure laws related to HIV/AIDS.

Prescriber signature	**Date**