Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Valcyte (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Valcyte (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Valcyte (valganciclovir)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Does the patient currently have any of the following comorbidities: A) Platelet Count less than 25,000/mm3 (uL), B) Hemoglobin less than 8g/dL, C) Absolute Neutrophil Count (ANC) less than 500/mm3 (uL)? Y N

   Please submit supporting labs.

2. Is the requested drug being prescribed for induction of therapy for active CMV retinitis in a patient with HIV/AIDS? Y N

   Please submit supporting medical documentation, notes and test results.

[If yes, then no further questions.]

3. Is the requested drug being prescribed for maintenance therapy or for patients with inactive CMV retinitis (e.g., CMV retinitis prophylaxis)? Y N

   Please submit supporting medical documentation, notes and test results.

   [If no, then skip to question 5.]

4. Is the patient CMV seropositive and have a CD4 count less than 100 cells/ mm3? Y N

   [No further questions.]

5. Is Valcyte being prescribed for CMV prophylaxis and preemptive therapy in patients at high and intermediate risk for CMV disease following a liver, heart, kidney, and/or kidney-pancreas transplant? Y N

   Please submit supporting medical documentation of date and type of transplant, notes and test results.

   [If no, then skip to question 8.]

6. Is this a request for maintenance therapy or continuation of therapy? Y N

   [If no, then no further questions.]

7. Does the patient have a positive PCR/quantitative viral load (CMV or EBV)? Y N

   Please submit supporting medical documentation, notes and test results.

   [No further questions.]

8. Is Valcyte being prescribed for prophylaxis in lung transplant? Y N

   [If no, then skip to question 11.]

9. Is this a request for maintenance therapy or continuation of therapy? Y N

   [If no, then no further questions.]

10. Does the patient have a positive PCR/quantitative viral load (CMV or EBV)? Y N

    Please submit supporting medical documentation, notes and test

results.

[No further questions.]

11. Is Valcyte being prescribed for treatment of CMV disease in a hematopoietic stem cell transplant patient? Y N

    [If no, then skip to question 14.]

12. Is this a request for maintenance therapy or continuation of therapy? Y N

    [If no, then no further questions.]

13. Does the patient have a positive PCR/quantitative viral load (CMV or EBV)? Y N

    Please submit supporting medical documentation, notes and test results.

    [No further questions.]

14. Does the patient have increased immunosuppression (directly or indirectly leading to activation of latently infected cells)? Y N

    [If no, then skip to question 17.]

15. Is this a request for maintenance therapy or continuation of therapy? Y N

    [If no, then no further questions.]

16. Does the patient have a positive PCR/quantitative viral load (CMV or EBV)? Y N

    Please submit supporting medical documentation, notes and test results.

    [No further questions.]

17. Does the patient have any of the following: A) Use of unfiltered blood products that are not leukocyte depleted (increases risk of CMV disease), B) Immunosuppressed transplant patient at increased risk of CMV due to environmental exposure such as being in crowds or public places or in a child care setting, C) Other immunomodulatory viruses (HHV-6), D) Bone marrow transplant recipient who is seropositive and receive marrow or stem cells from a seronegative individual or with Graft-vs-Host Disease (GvHD), E) Post-transplant with any of the following clinical conditions: fever, hepatitis, muscle pain, gastroenteropathy, leukopenia, pneumonitis, thrombocytopenia, and/or retinitis, F) Early reactivation, within 30 Y N

days post-transplant?

[If no, then skip to question 20.]

18. Is this a request for maintenance therapy or continuation of therapy? Y N

[If no, then no further questions.]

19. Does the patient have a positive PCR/quantitative viral load (CMV or EBV)? Y N

Please submit supporting medical documentation, notes and test results.

[No further questions.]

20. Does the patient have any of the following Epstein Barr Virus (EBV)/Post Transplant Lymphoproliferative Disorders: A) EBV viremia (EBV DNA detectable in blood by PCR analysis) , B) Post-transplant recipient presenting with PTLD symptomatology, C) EBV positive tissue analysis: biopsy with in situ hybridization for EBER (Epstein Barr Encoding RNA) ? Y N

Please submit supporting medical documentation, notes and test results.

[If no, then skip to question 23.]

21. Is this a request for maintenance therapy or continuation of therapy? Y N

[If no, then no further questions.]

22. Does the patient have a positive PCR/quantitative viral load (CMV or EBV)? Y N

Please submit supporting medical documentation, notes and test results.

[No further questions.]

23. Is the patient on current therapy or has taken previous therapy to treat infection in the past 90 days? Y N

    If yes, please provide supporting documentation of medication name(s), start and end date of therapy, reason(s) for discontinuing.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date