

**Aetna Better Health® of Virginia Request Form**  
**Cytokine and CAM Antagonists and Related Agents**  
**Fax back to 1-855-799-2553**

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

**MEMBER INFORMATION**

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Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

				-					-										
--	--	--	--	---	--	--	--	--	---	--	--	--	--	--	--	--	--	--	--

Gender:  Male  Female

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

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Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**DRUG INFORMATION**

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Does NOT require SA: Enbrel®, Humira®, or Inflectra®

Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

*(Form continued on next page.)*

Member's Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Member's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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Does the member meet the following criteria?

1. What is the member's diagnosis (*check all that apply*)?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Rheumatoid arthritis (RA)                          | <input type="checkbox"/> Adult Crohn's disease (CD) | <input type="checkbox"/> Pediatric Crohn's disease     |
| <input type="checkbox"/> Juvenile idiopathic arthritis (JIA)                | <input type="checkbox"/> Psoriatic arthritis (PsA)  | <input type="checkbox"/> Hidradenitis suppurativa (HS) |
| <input type="checkbox"/> Ankylosing spondylitis (AS)                        | <input type="checkbox"/> Ulcerative colitis (UC)    | <input type="checkbox"/> Uveitis (UV)                  |
| <input type="checkbox"/> Plaque psoriasis (PsO)                             |   |  |
| <input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (pJIA) |   |  |
| <input type="checkbox"/> Disease is classified as moderate to severe        |   |  |
| <input type="checkbox"/> Diagnosis not listed above: _____                  |   |  |

2. Does the member have a therapeutic failure to oral methotrexate?

- Yes     No     N/A

3. Does the member have a therapeutic failure to two of the preferred agents?

- Yes     No

If **Yes**, provide details of failure below:

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4. What is the medical necessity that supports the use of the requested medication (provide clinical evidence)?

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**Prescriber Signature (Required)**

**Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; Incomplete forms will delay the PA process.**

Submission of documentation does NOT guarantee coverage.