

**AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM**  
**GLP-1 RECEPTOR AGONISTS FOR CARDIOVASCULAR RISK REDUCTION**

**Fax back to: 1-855-799-2553**

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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: \_\_\_\_\_

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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For initial requests, continue below. For renewal requests, proceed to [Length of Authorization](#). If approved, initial authorizations are granted for 6 months. Renewal authorizations are granted for 12 months.

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

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

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

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

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

- FDA indicated medications only
- Must be prescribed by a cardiologist or vascular specialist for the member to receive authorization

*(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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- The member is 45 years of age or older; **AND**
- The medication is prescribed by a cardiologist or vascular specialist; **AND**
- The member has a clinical history of one of the following:
  - Myocardial infarction (MI), defined as cardiac biomarkers, an electrocardiogram, or cardiac imaging; **OR**
  - Stroke, defined as neurological dysfunction as a result of a hemorrhage or infarction; **OR**
  - Peripheral artery disease, as defined by intermittent claudication with ankle-brachial index less than 0.85 at rest, or peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease; **AND**
- The member has not had a MI, stroke, transient ischemic attack, or hospitalization for unstable angina in the last 60 days; **AND**
- The member has a BMI  $\geq 27$  kg/m<sup>2</sup>; **AND**
- The provider attests that the member received individualized healthy lifestyle counseling; **AND**
- The member does not have a previous diagnosis of diabetes; **AND**
- The member does not have pancreatitis, acute suicidal behavior/ideation, personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome

*(Form continued on next page.)*

**Member's Last Name:**

**Member's First Name:**

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**LENGTH OF AUTHORIZATION**

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**Renewal requests (see additional requirements below):**

- The member continues to meet the criteria
- The member is being treated with a maintenance dosage of the requested drug

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**Attachments**

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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.