Print Reset

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM
DUR MEDICATION KORLYM™, OR POTIGA™
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

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

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:**

DIAGNOSIS AND MEDICAL INFORMATION

KORLYM™ (mifepristone) – to receive a ONE (1) year approval for this drug, complete these questions:

1. Does the patient have a diagnosis of hypercortisolism with endogenous Cushing's syndrome?
   ☐ Yes ☐ No
2. Does the patient have type 2 diabetes mellitus?
   ☐ Yes ☐ No
3. Is the patient 18 years of age or older?
   ☐ Yes ☐ No

POTIGA™ (ezogabine) – to receive a ONE (1) year approval for this drug, complete these questions:

1. Is the patient using this as adjunctive treatment of partial-onset seizures?
   ☐ Yes ☐ No
2. Is the patient 18 years of age or older?
   ☐ Yes ☐ No
3. Is the patient on other anticonvulsant drugs?
   ☐ Yes ☐ No

   Please list: _____

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by patient records.

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

Submission of documentation does NOT guarantee coverage.