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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION MYTESI™ (CROFELEMER), RAVICTI® (GLYCEROL PHENYLBUTYRATE), OR SIGNIFOR® (PASIREOTIDE)

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

MYTESI™ (crofelemer) – to receive a THREE (3) month approval for this drug, complete the following questions.

1. Is the member 18 or over?
   ☐ Yes ☐ No
2. Does member have diagnosis of HIV/AIDS?
   ☐ Yes ☐ No
3. Is the member currently on anti-retroviral therapy?
   ☐ Yes ☐ No
4. What antidiarrheal(s), if any, has the member tried?
   Please list names: _____
5. Has infectious diarrhea been ruled out?
   ☐ Yes ☐ No
6. Does member have any other GI conditions or medications that can cause diarrhea?
   ☐ Yes ☐ No

RAVICTI® (glycerol phenylbutyrate) – to receive a SIX (6) month approval for this drug, complete the following questions.

1. Is the member 2 months of age or older?
   ☐ Yes ☐ No
2. Has the member been diagnosed with a urea cycle disorder?
   ☐ Yes ☐ No
3. Has the member been on a dietary protein restriction and/or an amino acid supplementation?
   ☐ Yes ☐ No
4. Is the prescriber a Pediatric endocrinologist?
   ☐ Yes ☐ No
5. Does the member have a diagnosis of acute hyperammonemia?
   ☐ Yes ☐ No
6. Has a baseline dermatologic evaluation been completed?
   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION *(continued)*

SIGNIFOR® (pasireotide) – to receive a SIX (6) month approval for this drug, complete the following questions.

1. Is the member 18 or over?
   ☐ Yes ☐ No
2. Does the member have a diagnosis of Cushing's disease?
   ☐ Yes ☐ No
3. Prior to initiating treatment, have the following tests been performed? Indicate "Yes" with date test was performed.
   a. Fasting Plasma Glucose: ☐ Yes ☐ No Date: _____
   b. Hemoglobin A1c: ☐ Yes ☐ No Date: _____
   c. Liver Tests: ☐ Yes ☐ No Date: _____
   d. Electrocardiogram (ECG): ☐ Yes ☐ No Date: _____
   e. Gallbladder Ultrasound: ☐ Yes ☐ No Date: _____
4. Does the member have a diagnosis for hepatic impairment (dosage adjustment)?
   ☐ Yes ☐ No
   Other treatment? Please list names: _____

_____

_____

_____

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.