Aetna Better Health® of Virginia REQUEST FORM Non-Preferred Incretin Mimetics 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:			

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(Form continued on next page.)

Aetna Better Health® of Virginia Request Form - Non-Preferred Incretin Mimetics

M	Member's Last Name: Member's First Name:	Member's First Name:					
DI	DIAGNOSIS AND MEDICAL INFORMATION						
	All drugs in this class are eligible to receive a twelve (12)-month approval. Comquestions.	plete the	e follow	ing			
1.	1. Does the member have a diagnosis of type 2 diabetes mellitus?						
	Yes No						
	If Yes , please specify which of the following lab values, performed within the used to confirm the member's diagnosis, along with the date of the result:	last 12 n	nonths,	have k	oeen	1	
	A1c . Value: Date:						
	Fasting blood glucose. Value: Date:						
	Random blood glucose level. Value: Date:						
2.	2. Has the member tried and failed an adequate trial of 2 different preferred pro	oducts?					
	Yes No						
	If Yes, please specify the drug, the length of the member's trial, and reason f	or discor	ntinuati	on.			
	Drug 1:				_		
	Drug 2:				_		
Pr	Prescriber Signature (Required)	Date					
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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.

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