AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION RHAPSIDO® (remibrutinib)

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: _____

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

RHAPSIDO® – to receive a one year approval for this drug, complete the following questions.

1. Is the prescriber a specialist in the area of the member's diagnosis (e.g., dermatologist, allergist, immunologist) or has the prescriber consulted with a specialist in the area of the member's diagnosis?

   ☐ Yes ☐ No

2. Is the member 18 years of age or older?

   ☐ Yes ☐ No

3. Does the member have a confirmed diagnosis of chronic spontaneous urticaria (CSU), characterized by persistent hives and itching, with or without angioedema, for at least 6 weeks?

   ☐ Yes ☐ No

4. Will the member continue second-generation H1-antihistamine therapy in combination with Rhapsido, unless a documented contraindication, hypersensitivity, or intolerance to the antihistamine exists?

   ☐ Yes ☐ No

5. Does the member have mild, moderate, or severe hepatic impairment (Child-Pugh Class A, B or C)?

   ☐ Yes ☐ No

(Form continued on next page.)

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

For renewal, complete the following questions to receive a 1-year approval:

6. Does the member continue to meet the above criteria (questions 1 through 5)?
   ☐ Yes ☐ No
7. Does the member continue to experience clinical benefit from the requested treatment?
   ☐ Yes ☐ No

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.