

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM
DUR MEDICATION VEOZAH™ (fezolinetant)
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

For initial approval, complete the following questions to receive a 3-months approval:

1. Is the member 18 years of age or older?
 Yes No

2. Does the member have a diagnosis of menopause with moderate to severe vasomotor symptoms?
 Yes No

3. Has the member had a trial and failure, or is not a candidate for, hormone therapy?
 Yes No

4. Does the member have cirrhosis?
 Yes No

5. Does the member have severe renal impairment or end-stage renal disease?
 Yes No

6. Will the member avoid concomitant therapy with weak, moderate, or strong CYP1A2 inhibitors (e.g., fluvoxamine, mexiletine, cimetidine)?
 Yes No

7. Does the prescriber attest that baseline liver function tests have been conducted and total bilirubin, alanine aminotransferase (ALT), and aspartate aminotransferase (AST) levels are not elevated ≥ 2 times the upper limit of normal (ULN)?
 Yes No

8. Does the prescriber attest that liver function testing follow-up will be conducted as outlined in prescribing information?
 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:

9. Does the member continue to meet the above criteria?

Yes No

10. Does the member have symptom improvement?

Yes No

11. Has the member been assessed for adverse effects (e.g., ALT or AST > 3 times the ULN)?

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.