Print Reset

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION VYALEV™ (foscarbidopa and foslevodopa)

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

For initial approval, complete the following questions to receive a 12-months approval:

1. Is the member 18 years of age or older?
   ☐ Yes ☐ No
2. Does the member have Parkinson's disease with motor fluctuations?
   ☐ Yes ☐ No
3. Is the member diagnosed with levodopa-responsive idiopathic Parkinson's disease?
   ☐ Yes ☐ No
4. Is the member currently taking ≥ 400 mg/day of levodopa equivalents?
   ☐ Yes ☐ No
5. Is the member's motor fluctuations inadequately controlled with carbidopa/levodopa therapy?
   ☐ Yes ☐ No
6. Does the member have a minimum daily average "Off" time of 2.5 hours per day?
   ☐ Yes ☐ No

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

7. Does the member continue to meet the above criteria?
   ☐ Yes ☐ No
8. 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.