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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION XDEMVY™ (lotilaner)

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 approval, complete the following questions to receive a 6-weeks approval (one course of therapy):

1. Is Xdemvy prescribed by or in consultation with an ophthalmologist or optometrist?
   ☐ Yes ☐ No
2. Is the member 18 years of age or older?
   ☐ Yes ☐ No
3. Does the member have a diagnosis of Demodex blepharitis as determined by all of the following:
   - Presence of at least mild erythema of the upper eyelid margin
   - Presence of mites upon examination of eyelashes or presence of collarettes on more than 10 lashes

   ☐ 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.