

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM**Apolipoprotein(A) Inhibitors****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

To receive a 12-month initial approval for this drug, complete the following questions:

1. Does the member meet one of the following diagnoses:

- Does the member have a diagnosis of familial chylomicronemia syndrome confirmed by **one** of the following:
 - Genetic confirmation of bi-allelic pathogenic variants in affected genes (e.g., LPL, ApoA5, ApoC2, LMF1, GPIHBP1, G3PDH1); **OR**
 - **All** of the following:
 - Fasting triglyceride (TG) levels greater than 880 mg/dL for 3 consecutive measurements; **AND**
 - Secondary causes of hypertriglyceridemia have been ruled out (e.g., alcohol use, chronic kidney disease, hypothyroidism, uncontrolled diabetes, medications [e.g., atypical antipsychotics, beta-blockers, corticosteroids, oral estrogens]); **AND**
 - History of pancreatitis or unexplained recurrent abdominal pain

☐ Yes ☐ No

2. **For Tryngolza® only:** Will this be used to reduce triglycerides and the risk of acute pancreatitis in adults with severe hypertriglyceridemia?

☐ Yes ☐ No

Please answer the remaining questions to receive an initial approval:

3. Has the member had a treatment failure, maximum dosing with, or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants?

☐ Yes ☐ No

4. Does the provider attest that this medication will be used as an adjunct to diet?

☐ Yes ☐ No

5. List previous medications **(include drug name/dose):**

(Form continued on next page.)

Member's Last Name:

Member's First Name:

For renewal, complete the following questions to receive a 12-month approval:

6. Does the member continue to meet the above criteria (questions 1 through 4)? **AND**
☐ Yes ☐ No
7. Does the member continue to experience clinical benefit from the requested treatment? **AND**
☐ Yes ☐ No
8. Is the member free from unacceptable toxicity?
☐ 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.