

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

Cytokine and CAM Antagonists and Related Agents

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:

				-					-										
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Fax Number:

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DRUG INFORMATION

Does NOT require PA: Enbrel®, Humira®, or infliximab (gen Remicade®)

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:

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DIAGNOSIS AND MEDICAL INFORMATION

Does the member meet the following criteria?

1. What is the member's diagnosis (*check all that apply*)?

- Rheumatoid arthritis (RA)
- Juvenile idiopathic arthritis (JIA)
- Ankylosing spondylitis (AS)
- Plaque psoriasis (PsO)
- Polyarticular juvenile idiopathic arthritis (pJIA)
- Disease is classified as moderate to severe
- Diagnosis not listed above: _____
- Adult Crohn's disease (CD)
- Psoriatic arthritis (PsA)
- Ulcerative colitis (UC)
- Pediatric Crohn's disease
- Hidradenitis suppurativa (HS)
- Uveitis (UV)

2. Does the member have a therapeutic failure to oral methotrexate?

- Yes
- No
- N/A

3. Does the member have a therapeutic failure to one of the preferred agents?

- Yes
- No

If **Yes**, provide details of failure below:

4. What is the medical necessity that supports the use of the requested medication (provide clinical evidence)?

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.