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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

GLP-1 RECEPTOR AGONISTS FOR CARDIOVASCULAR RISK REDUCTION

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

For initial requests, continue below. For renewal requests, proceed to Length of Authorization. If approved, initial authorizations are granted for 6 months. Renewal authorizations are granted for 12 months.

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

- **FDA indicated medications only**
- **Must be prescribed by a cardiologist or vascular specialist for the member to receive authorization**

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

- ☐ The member is 45 years of age or older; **AND**
- ☐ The medication is prescribed by a cardiologist or vascular specialist; **AND**
- ☐ The member has a clinical history of one of the following:
  - ☐ Myocardial infarction (MI), defined as cardiac biomarkers, an electrocardiogram, or cardiac imaging; **OR**
  - ☐ Stroke, defined as neurological dysfunction as a result of a hemorrhage or infarction; **OR**
  - ☐ Peripheral artery disease, as defined by intermittent claudication with ankle-brachial index less than 0.85 at rest, or peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease; **AND**
- ☐ The member has not had a MI, stroke, transient ischemic attack, or hospitalization for unstable angina in the last 60 days; **AND**
- ☐ The member has a BMI ≥ 27 kg/m^2; **AND**
- ☐ The provider attests that the member received individualized healthy lifestyle counseling; **AND**
- ☐ The member does not have a previous diagnosis of diabetes; **AND**
- ☐ The member does not have pancreatitis, acute suicidal behavior/ideation, personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2 syndrome

(Form cntinued on next page.)

Member's Last Name: **Member's First Name:**

LENGTH OF AUTHORIZATION

Renewal requests (see additional requirements below):

- ☐ The member continues to meet the criteria
- ☐ The member is being treated with a maintenance dosage of the requested drug

☐ **Attachments**

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 SA process.
Submission of documentation does NOT guarantee coverage.