

**AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM**

**Non-Preferred Incretin Mimetics**

**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**

---

All drugs in this class are eligible to receive a twelve (12)-month approval. Complete the following questions.

1. Does the member have a diagnosis of type 2 diabetes mellitus?

Yes  No

If **Yes**, please provide the value of the lab that was performed within the last 12 months and has been used to confirm the member's diagnosis, along with the date of the result (A1c of greater than or equal to 6.5 is required for first starts):

**A1c Value:** \_\_\_\_\_ **Date:** \_\_\_\_\_

2. Has the member tried and failed an adequate trial of 2 different preferred products?

Yes  No

If **Yes**, please specify the drug, the length of the member's trial, and reason for discontinuation.

Drug 1: \_\_\_\_\_

Length of Trial: \_\_\_\_\_ Reason for Discontinuation: \_\_\_\_\_

Drug 2: \_\_\_\_\_

Length of Trial: \_\_\_\_\_ Reason for Discontinuation: \_\_\_\_\_

---

**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.