AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

NON-PREFERRED COLONY STIMULATING FACTORS

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: | | | – | | | – | | | | |

Expected Pregnancy Term Date: | | | – | | | – | | | | |

Requested Start Date: | | | – | | | – | | | | |

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 Colony Stimulating Factors– to receive an approval for this drug, complete the following questions.

Initial Request for a non-preferred colony stimulating factors (CSF):

1. If the member has an FDA approved indication, **ONE** of the following:

   a. Is the members age within FDA labeling for the requested indication for the requested agent?

   ☐ Yes ☐ No

   b. Has the provider included information in support of using the requested agent for the member's age for the requested indication?

   ☐ Yes ☐ No

Medical Necessity: Provide clinical evidence that supports the use of the requested medication for indications supported by compendia (Compendia allowed: DrugDex 1, 2a or 2b level of evidence, NCCN 1, 2a or 2b recommended use.)

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☐ Attachments

(Form continued on next page.)

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

Renewal Request

1. Does the member continue to meet the initial criteria? **AND**

☐ Yes ☐ No

2. Does the member have an absence of unacceptable toxicity to the drug? **AND**

☐ Yes ☐ No

3. Is the member being appropriately monitored for a beneficial response to therapy?

☐ 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.