

Welireg™ (Belzutifan) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy billing (NDC: _____) Start Date (or date of next dose): _____

Dose: _____ Dosing Regimen: _____

Billing Provider Information

Pharmacy NPI: _____ Pharmacy Name: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:

von Hippel-Landau (VHL) disease

A. Please indicate any diagnosis below associated with VHL disease (please check all that apply):

Renal cell carcinoma

Central nervous system hemangioblastomas

Pancreatic neuroendocrine tumor

Other, please list: _____

B. Does the member require immediate surgery? Yes No

Renal Cell Carcinoma (RCC)

A. Is diagnosis advanced RCC? Yes No

B. Has member received at least 2 lines of systemic therapy, including a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI)? Yes No

C. Will belzutifan be used as a single agent? Yes No

If diagnosis is not listed above, please indicate diagnosis: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does the member have any evidence of progressive disease while on belzutifan? Yes No

3. Has the member experienced any adverse drug reactions related to belzutifan therapy? Yes No

If yes, please specify adverse reactions: _____

Additional Information: _____

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.
All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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