AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

JOURNAVX

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: _____

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: _____

Length of Authorization: 14 days can only be approved every 30 days

(Form continued on next page.)

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

DIAGNOSIS AND MEDICAL INFORMATION

1. Is the member 18 years of age or older? **AND**

   ☐ Yes ☐ No

2. Does the prescriber attest that the member has moderate to severe acute pain? **AND**

   ☐ Yes ☐ No

3. Has the member tried and failed two of the following non-opioid therapies covered without PA in the past 30 days? *(select all that apply)* **AND**

   ☐ Acetaminophen

   ☐ Diclofenac sodium gel

   ☐ Lidocaine patch

   ☐ NSAIDs (oral)

   ☐ Other: _____

4. If the member meets the criteria below, has the prescriber advised the member to use an additional nonhormonal contraceptive or to use alternative contraceptives during Journavx treatment and for 28 days after discontinuation of Journavx?

   - The member is of childbearing potential
   - The member is 18 to 45 years of age
   - The member is using hormonal contraceptives containing progestins other than levonorgestrel and norethindrone

   ☐ Yes ☐ No

5. Does the prescriber attest that the member is neither pregnant, planning to become pregnant, nor breastfeeding?

   ☐ Yes ☐ No

If the member is being treated for moderate to severe acute pain and has a history of substance use disorder, please contact the member's MCO help desk directly.

(Form continued on next page.)

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

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.