aetna®

Adcetris® (brentuximab vedotin) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Oncologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Phone: _____ Fax: _____
Address: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Adcetris (brentuximab vedotin): Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):
☐ Yes ☐ No Has the member been diagnosed with progressive multifocal leukoencephalopathy (PML)?
☐ Yes ☐ No Will Adcetris (brentuximab vedotin) be used in combination with Blenoxane (bleomycin)?

For Initiation Requests (clinical documentation required):
Adult T-cell leukemia/lymphoma (ATLL):
Which subtype of ATLL does the patient present with ☐ Acute ☐ Lymphoma ☐ Smoldering ☐ Chronic ☐ Other- please explain: _____
☐ Yes ☐ No Is CD30 positive expression present?
☐ Yes ☐ No Will Adcetris (brentuximab vedotin) be used as a single agent?
☐ Yes ☐ No Will Adcetris (brentuximab vedotin) be used as second line therapy?
→ ☐ Yes ☐ No Will it be used as subsequent therapy?
☐ Yes ☐ No Did the patient receive HDT/ASCR (high-dose therapy and autologous stem cell rescue)?
Please provide start date of high-dose therapy: ____/____/____
Please provide date of the transplant: ____/____/____
→ ☐ Yes ☐ No Is the patient a non-responder to first-line therapy?

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

Breast implant-associated anaplastic large cell lymphoma (ALCL):

☐ Yes ☐ No Will Adcetris (brentuximab vedotin) be used as adjuvant systemic therapy?

Which of the following applies to the patient's disease status?

→ Please select: ☐ Localized disease to capsule ☐ Localized disease to implant ☐ Localized disease to breast

☐ Other: please explain: _____

Will Adcetris (brentuximab vedotin) be used following an incomplete excision, partial caspsulectomy, or extended disease?

→ ☐ Yes ☐ No Incomplete excision

☐ Yes ☐ No Partial capsulectomy

→ ☐ Yes ☐ No Does the patient have residual disease?

☐ Yes ☐ No Extended disease

→ Please indicate the disease stage: ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

☐ Other: _____

CD30+ AIDS related diffuse large B-cell lymphoma, primary effusion lymphoma, and HHV8-positive diffuse large B- cell lymphoma, not otherwise specified (NOS):

Please indicate which of the following pertains to the patient:

☐ AIDS-related diffuse large B-cell lymphoma ☐ AIDS-related primary effusion lymphoma

☐ AIDS-related HHV8-positive diffuse large B- cell lymphoma, not otherwise specified (NOS)

☐ Yes ☐ No Is CD30 positive expression present?

☐ Yes ☐ No Is the patient a non-candidate for high-dose therapy?

☐ Yes ☐ No Will Adcetris (brentuximab vedotin) be used as second-line or subsequent therapy for relapsed disease?

→ Please select: ☐ Second-line therapy ☐ Subsequent therapy

Classic Hodgkin lymphoma:

Please select how Adcetris (brentuximab vedotin) will be used: ☐ First line therapy ☐ Second line therapy ☐ Subsequent therapy

For first line therapy:

Please indicate the disease stage: ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

☐ Yes ☐ No Will Adcetris (brentuximab vedotin) be given in combination with chemotherapy?

Please provide the chemotherapeutic regimen the patient will be on: _____

For second line and subsequent therapy:

Please select which of the following Adcetris (brentuximab vedotin) will be used for**:**

☐ **After failure of autologous stem cell transplant (ASCT)**

Please provide the date of the transplant: ____/____/____

☐ Yes ☐ No Will it be used as a single agent?

☐ **After failure of at least 2 different prior multi agent chemotherapeutic regimens**

Please provide the date of the transplant: ____/____/____

Please indicate the 1st chemotherapy regimen and date range of trial: Regimen: _____

Date range: ____/____/____ to ____/____/____

Please indicate the 2nd chemotherapy regimen and date range of trial: Regimen: _____

Date range: ____/____/____ to ____/____/____

☐ Yes ☐ No Will Adcetris (brentuximab vedotin) be used as a single agent?

☐ **Maintenance therapy**

☐ Yes ☐ No Will Adcetris (brentuximab vedotin) be used for relapsed or refractory disease? ☐ Relapsed disease ☐ Refractory disease

☐ Yes ☐ No Has the patient received HDT/ASCR (High dose therapy/autologous stem cell rescue)?

→ Please provide the date of the transplant: ____/____/____

☐ Yes ☐ No Has the patient received Adcetris (brentuximab vedotin) in the past?

☐ **Palliative therapy**

☐ Yes ☐ No Will it be used as a single agent?

☐ Yes ☐ No Will it be used for relapsed or refractory disease? ☐ Relapsed disease ☐ Refractory disease

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

Diffuse large B-cell lymphoma:

☐ Yes ☐ No Will Adcetris (brentuximab vedotin) be used for refractory or relapsed disease? ☐ Relapsed disease ☐ Refractory disease
☐ Yes ☐ No Is CD30 positive expression present?
☐ Yes ☐ No Is the patient a non-candidate for high-dose therapy?
Please identify if Adcetris (brentuximab vedotin) is being used as second-line or subsequent therapy: ☐ Second-line therapy ☐ Subsequent therapy

Lymphomatoid papulosis (LyP) or LyP with extensive lesions:

Please indicate the type: ☐ Lymphomatoid papulosis (LyP) ☐ Lymphomatoid papulosis (LyP) with extensive lesions
☐ Yes ☐ No Is the patient's disease symptomatic?
☐ Yes ☐ No Is the patient refractory to all primary treatment options?
☐ Yes ☐ No Will Adcetris (brentuximab vedotin) be used as a single-agent?

Mycosis fungoides/Sezary syndrome:

Please select which of the following the patient is being treated for: ☐ Mycosis fungoides ☐ Sezary syndrome

Primary cutaneous anaplastic large cell lymphoma (ALCL) with multifocal lesions or cutaneous ALCL with regional nodes (excludes systemic ALCL):

Please select which applies to the patient: ☐ Primary cutaneous anaplastic large cell lymphoma (ALCL) with multifocal lesions
☐ Cutaneous ALCL with regional nodes (excludes systemic ALCL)
☐ Yes ☐ No Will Adcetris (brentuximab vedotin) be used as a single-agent therapy?
Which of the following will Adcetris (brentuximab vedotin) be used for: ☐ Primary treatment ☐ Refractory disease ☐ Relapsed disease

Primary cutaneous diffuse large B-cell lymphoma, leg type:

Is Adcetris (brentuximab vedotin) being used as second-line or subsequent therapy? ☐ Second-line therapy ☐ Subsequent therapy
☐ Yes ☐ No Is CD30 positive expression present?
☐ Yes ☐ No Will Adcetris (brentuximab vedotin) be used for refractory or relapsed disease? ☐ Relapsed disease ☐ Refractory disease
☐ Yes ☐ No Is the patient a non-candidate for high-dose therapy?

Systemic anaplastic large cell lymphoma (excluding cutaneous ALCL), CD30+ peripheral T-cell lymphoma (PTCL), or CD30+ angioimmunoblastic T-cell lymphoma:

Please select which of the following the patient is being treated for: ☐ Systemic anaplastic large cell lymphoma (excluding cutaneous ALCL)
☐ CD30+ peripheral T-cell lymphoma (PTCL) ☐ CD30+ angioimmunoblastic T-cell lymphoma
Will Adcetris (brentuximab vedotin) be used as second-line or subsequent therapy? ☐ Second-line therapy ☐ Subsequent therapy
Will Adcetris (brentuximab vedotin) be used for relapsed or refractory disease? ☐ Relapsed disease ☐ Refractory disease

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Has the patient experienced disease progression, developed intolerance, or toxicity while on Adcetris (brentuximab vedotin)?
→ Please select: ☐ Disease progression ☐ Treatment intolerance ☐ Unacceptable toxicity

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.