



Bendamustine
(Treanda[®], Bendeka[®], Belrapzo[™])
Medication Precertification Request

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

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

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:		DOB:	
Address:			City:		State: ZIP:
Home Phone:		Work Phone:		Cell Phone:	
Email:		Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms Allergies:			

B. INSURANCE INFORMATION

Aetna Member ID #:		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #:		If yes, provide ID#: _____ Carrier Name: _____	
Insured:		Insured:	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:	

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:		State: ZIP:
Phone:		Fax:		St Lic #: NPI #: DEA #: UPIN:	
Provider Email:			Office Contact Name:		Phone:
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: <i>Patient Selected choice</i>	
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy	
<input type="checkbox"/> Outpatient Infusion Center Phone: _____		<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____	
Center Name: _____		Name: _____	
<input type="checkbox"/> Home Infusion Center Phone: _____		Address: _____	
Agency Name: _____		Phone: _____ Fax: _____	
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____ PIN: _____	
Address: _____			

E. PRODUCT INFORMATION

Request is for: Treanda Bendeka Belrapzo
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 Initiation Requests (Clinical documentation required for all requests):

AIDS-related B-cell lymphoma
 Yes No Will the requested drug be used as second-line or subsequent therapy?
 Yes No Is the patient a candidate for transplant?

Adult T-cell leukemia/lymphoma (ATLL)
 Yes No Will the requested drug be used as a single agent?
 Yes No Will the requested drug be used as second-line or subsequent therapy?

Chronic lymphocytic leukemia (CLL) without chromosome 17p deletion or without TP53 mutation

Classical Hodgkin lymphoma
 Yes No Will the requested drug be used as second line, subsequent therapy, or palliative therapy?
Please indicate the requested regimen:
 The requested drug will be used as a single agent
 The requested drug will be used in combination with brentuximab vedotin
 The requested drug will be used in combination with gemcitabine and vinorelbine
 None of the above

Cutaneous anaplastic large cell lymphoma (ALCL)
 Yes No Will the requested drug be used as a single agent?
 Yes No Is the disease relapsed or refractory?

Diffuse large B-cell lymphoma
 Yes No Will the requested drug be used as second-line or subsequent therapy?
 Yes No Is the patient a candidate for transplant?

Continued on next page



**Bendamustine
(Treanda®, Bendeka®, Belrapzo™)
Medication Precertification Request**

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

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

- Follicular lymphoma**
- Hepatosplenic Gamma-Delta T-Cell Lymphoma**
 - Yes No Will the requested drug be used as a single agent?
 - Yes No Is the disease refractory?
- High grade B-cell lymphoma**
 - Yes No Will the requested drug be used as second-line or subsequent therapy?
 - Yes No Is the patient a candidate for transplant?
- Histologic transformation of follicular lymphoma to diffuse large B-cell lymphoma**
Please indicate how many lines of chemoimmunotherapy the patient has received: _____
- Histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma**
Please indicate how many lines of chemoimmunotherapy the patient has received: _____
- Mantle cell lymphoma**
Please indicate the requested regimen:
 - The requested drug will be used as a single agent
 - The requested drug will be used in combination with rituximab
 - None of the above
- Marginal zone lymphoma (nodal, gastric MALT, non-gastric MALT, splenic)**
Please indicate the requested regimen:
 - The requested drug will be used in combination with rituximab
 - The requested drug will be used in combination with obinutuzumab (Gazyva)
 - None of the above
- Multiple myeloma**
Please indicate the requested regimen:
 - The requested drug will be used as a single agent
 - The requested drug will be used in combination with lenalidomide (Revlimid) and dexamethasone
 - The requested drug will be used in combination with bortezomib (Velcade) and dexamethasone
 - None of the above
 - Yes No Is the disease relapsed or progressive?
- Mycosis fungoides (MF)**
- Post-transplant lymphoproliferative disorders**
 - Yes No Will the requested drug be used as second-line or subsequent therapy?
- Peripheral T-cell Lymphoma (PTCL)**
 - Yes No Will the requested drug be used as a single agent?
 - Yes No Will the requested drug be used as second-line or subsequent therapy?
- Primary cutaneous B-cell lymphoma**
 - Yes No Will the requested drug be used as second-line or subsequent therapy?
 - Yes No Is the patient a candidate for transplant?
- Sezary syndrome (SS)**
- Small cell lung cancer**
 - Yes No Will the requested drug be used as a single agent?
 - Yes No Will the requested drug be used as subsequent therapy?
- Small lymphocytic lymphoma (SLL) without chromosome 17p deletion or without TP53 mutation**
- Waldenström’s macroglobulinemia/lymphoplasmacytic lymphoma**
Please indicate the requested regimen:
 - The requested drug will be used as a single agent
 - The requested drug will be used in combination with rituximab
 - None of the above

For Continuation Requests (clinical documentation required for all requests):

Yes No Is there evidence of unacceptable toxicity or disease progression on the current regimen?

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.