aetna®

Besponsa® (inotuzumab ozogamicin) 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:	Email:	

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 Email:		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: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Besponsa: 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 for all requests)

☐ Yes ☐ No Does the patient have a documented diagnosis of acute lymphoblastic leukemia (ALL)?
☐ Yes ☐ No Is there documentation that the patient has B-cell precursor acute lymphoblastic leukemia (B-ALL)?
Please select which of the following applies to the patient's disease:
☐ Relapsed CD22 positive (i.e., ≥5% blasts CD22-positive) ☐ Refractory CD22 positive (i.e., ≥5% blasts CD22-positive)
☐ Yes ☐ No Does the patient have Philadelphia chromosome-positive (Ph+) or Philadelphia chromosome-negative (Ph-) disease?
→ ☐ Philadelphia chromosome-positive (Ph+) disease
☐ Yes ☐ No Has the patient failed treatment with at least one tyrosine kinase inhibitor? (Check all that apply)
→ ☐ imatinib (Gleevec) ☐ dasatinib (Sprycel) ☐ nilotinib (Tasigna)
☐ bosutinib (Bosulif) ☐ ponatinib (Inclusig)
Please provide the tyrosine kinase inhibitor treatment date range: ____/____/____ - ____/____/____
☐ Yes ☐ No Has the patient failed standard chemotherapy treatment?
→ Please indicate the treatment: _____
Date range: ____/____/____ - ____/____/____
☐ Philadelphia chromosome-negative (Ph-) disease
☐ Yes ☐ No Has the patient failed treatment with at least one induction chemotherapy regimen for ALL?
→ Please indicate the treatment(s): _____
Date range: ____/____/____ - ____/____/____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

For Continuation Requests:

Please indicate the number of cycles the patient have already received: _____

☐ Yes ☐ No Has the patient developed hepatic veno-occlusive disease (VOD) (also known as sinusoidal obstruction syndrome) or other severe liver toxicity?

☐ hepatic veno-occlusive disease (VOD) ☐ other severe liver 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.