



# Firmagon® (degarelix) Medication Precertification Request

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

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

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

<b>Place of Administration:</b>		<b>Dispensing Provider/Pharmacy: Patient Selected choice</b>			
<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:  Firmagon (degarelix) 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):**

Prostate cancer

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

Prostate cancer

Yes  No Has the patient experienced clinical benefit while receiving requested drug?

Yes  No Has the patient experienced an unacceptable toxicity while receiving the requested drug?

## 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.