aetna®

Gazyva® (obinutuzumab) 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:	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 #: _____
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: _____
Address: _____
☐ Administration code(s) (CPT): _____

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 Gazyva (obinutuzumab)**: Dose:** _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary Indication: _____ ☐ Other: _____

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 active hepatitis B infection?

For chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL)

☐ Yes ☐ No Will Gazyva (obinutuzumab) be used as a single agent?
☐ Yes ☐ No Will Gazyva (obinutuzumab) be used in combination with chlorambucil?
☐ Yes ☐ No Will Gazyva (obinutuzumab) be used in combination with bendamustine?

For follicular lymphoma

☐ Yes ☐ No Will Gazyva (obinutuzumab) be used as first line therapy?
→ Please select which combination Gazyva (obinutuzumab) will be used with:
☐ CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) regimen
☐ CVP (cyclophosphamide, vincristine, and prednisone) regimen
☐ In combination with bendamustine

☐ Yes ☐ No Will Gazyva (obinutuzumab) be used as second-line or subsequent therapy?
→ Please identify if Gazyva (obinutuzumab) is being requested to treat refractory or progressive disease? ☐ Refractory ☐ Progressive
☐ Yes ☐ No Will Gazyva (obinutuzumab) be used in combination with bendamustine?

☐ Yes ☐ No Will Gazyva (obinutuzumab) be used as maintenance therapy for treatment as first-line consolidation or extended dosing?
→ Please select which one: ☐ First-line consolidation ☐ Extended dosing

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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.

☐ Yes ☐ No Will Gazyva (obinutuzumab) be used as second-line consolidation or extended dosing?
→ Please select which one: ☐ Second-line consolidation ☐ Extended dosing

☐ Yes ☐ No Is there clinical evidence that the patient is refractory to rituximab regimen?
→ Please provide the date range of the rituximab therapy: ____/____/____ to ____/____/____

For gastric MALT lymphoma, nodal marginal zone lymphoma, non-gastric MALT lymphoma, or Splenic marginal zone lymphoma

☐ Yes ☐ No Will Gazyva (obinutuzumab) be used as second-line or subsequent therapy?
→ Please identify if Gazyva (obinutuzumab) is being requested to treat recurrent or progressive disease:
☐ Recurrent ☐ Progressive

☐ Yes ☐ No Will Gazyva (obinutuzumab) be used in combination with bendamustine?

☐ Yes ☐ No Will Gazyva (obinutuzumab) be used as maintenance therapy for treatment as second-line consolidation or extended dosing?
→ Please select which one: ☐ Second-line consolidation ☐ Extended dosing

☐ Yes ☐ No Is there clinical evidence that the patient is refractory to rituximab regimen?
→ Please provide the date range of the rituximab therapy: ____/____/____ to ____/____/____

☐ Yes ☐ No Was the rituximab refractory patient treated with obinutuzumab and bendamustine regimen for recurrent disease?
Please provide the date range of the obinutuzumab and bendamustine therapy: ____/____/____ to ____/____/____

For primary cutaneous B-cell lymphoma

☐ Yes ☐ No Will Gazyva (obinutuzumab) be used to treat primary cutaneous marginal zone lymphoma or follicle center lymphoma?
→ ☐ Yes ☐ No Will Gazyva (obinutuzumab) be used as maintenance therapy to treat rituximab-refractory disease?
Please provide the date range of the rituximab therapy: ____/____/____ to ____/____/____
☐ Yes ☐ No Will Gazyva (obinutuzumab) be used as second-line extended dosing?
→ ☐ Primary cutaneous marginal zone lymphoma ☐ Follicle center lymphoma
Please select the type of disease being treated:
☐ Very extensive disease
☐ Refractory generalized T3 cutaneous disease
☐ Refractory disease
→ ☐ Yes ☐ No Will Gazyva (obinutuzumab) will be used as second-line **or** subsequent therapy?
☐ Second-line therapy ☐ Subsequent therapy
☐ Yes ☐ No Will Gazyva (obinutuzumab) be used in combination with bendamustine?
☐ Progressive generalized extracutaneous disease
→ ☐ Yes ☐ No Will Gazyva (obinutuzumab) will be used as second-line **or** subsequent therapy?
☐ Second-line therapy ☐ Subsequent therapy
☐ Yes ☐ No Will Gazyva (obinutuzumab) be used in combination with bendamustine?

For continuation requests:

☐ Yes ☐ No Has the patient experienced significant disease progression while on Gazyva (obinutuzumab)?

☐ Yes ☐ No Has the patient experienced unacceptable toxicity while on Gazyva (obinutuzumab)?

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.