aetna®

Herceptin® (trastuzumab), Kadcyla® (ado-trastuzumab) and Perjeta® (pertuzumab) 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: _____
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: ☐ **Herceptin (trastuzumab)** ☐ **Perjeta (pertuzumab)** ☐ **Kadcyla (ado-trastuzumab emtansine)**
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:
☐ Yes ☐ No Does the patient have HER2 protein overexpression documented by one of the following:
→ **Check all that apply**:
☐ Immunohistochemistry (IHC) Assay level of 3+
→ Results _____ Date of Test: ____/____/____
☐ Positive Fluorescent in situ hybridization (FISH) HER2 gene copy of greater than 6 signals/nucleus
→ Results _____ Date of Test: ____/____/____
☐ Positive Fluorescent in situ hybridization (FISH) HER2 gene/ chromosome 17 ratio greater than or equal to 2.0
→ Results _____ Date of Test: ____/____/____

HERCEPTIN (trastuzumab):
☐ **Esophageal adenocarcinomas** ☐ **Gastric adenocarcinoma** ☐ **Esophageal-gastric junction adenocarcinoma**
☐ Yes ☐ No Will trastuzumab (Herceptin) be used as palliative therapy?
☐ Yes ☐ No Will trastuzumab (Herceptin) be used in combination with systemic chemotherapy?
→ Please provide the name of the systemic chemotherapy: _____

Salivary gland tumors
☐ Yes ☐ No Does the patient have recurrent disease with distant metastases?
Please indicate how trastuzumab (Herceptin) will be used: ☐ single agent ☐ Other: Please explain: _____
☐ in combination with systemic chemotherapy: Name of systemic chemotherapy: _____

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

HER2 positive breast cancer

☐ Yes ☐ No Does the patient have recurrent, metastatic, stage IV disease or leptomeningeal metastases from breast cancer (as intracerebrospinal fluid treatment)? ☐ Recurrent disease ☐ Metastatic disease ☐ Stage IV disease ☐ Leptomeningeal metastases from breast cancer (as intracerebrospinal fluid treatment)

→ ☐ Yes ☐ No Will trastuzumab (Herceptin) be used as pre-operative (neoadjuvant) systemic therapy?

→ Please select in which of the following settings trastuzumab (Herceptin) will be used:
☐ Node-positive disease likely to become node-negative with pre-operative systemic therapy
☐ Locally advanced disease ☐ Individuals who fulfill criteria for breast-conserving surgery except for tumor size
☐ None of the above

☐ Yes ☐ No Will trastuzumab (Herceptin) be used as adjuvant therapy?

☐ Yes ☐ No Will trastuzumab (Herceptin) be used as part of a complete treatment regimen?

PERJETA (pertuzumab) with HERCEPTIN (trastuzumab): *(please ensure dosing and instructions for both drugs are documented in section E)*

HER2 positive breast cancer

Please select which type of treatment Perjeta (pertuzumab) and Herceptin (trastuzumab) is being used for:

☐ Adjuvant therapy

→ ☐ Yes ☐ No Is the patient's disease node-positive or at high-risk for recurrence?
Please select: ☐ Node-positive ☐ At high-risk for recurrence ☐ Other: _____

☐ Preoperative (neoadjuvant) therapy

→ Please select in which of the following settings Perjeta (pertuzumab) with Herceptin (trastuzumab) will be used:
☐ Node-positive disease likely to become node-negative with pre-operative systemic therapy
☐ Individuals who desire breast preservation and fulfill criteria for breast-conserving surgery except for tumor size
☐ Locally advanced disease ☐ None of the above

☐ Other

→ Please indicate which applies to the patient's disease: ☐ Recurrent disease ☐ Metastatic disease

☐ Yes ☐ No Does the patient have symptomatic visceral disease or visceral crisis?

→ Please specify: ☐ Symptomatic visceral disease ☐ Visceral crisis

KADCYLA (ado-trastuzumab emtansine):

☐ Yes ☐ No Does the patient have a documented diagnosis of HER2-positive lung cancer?

→ ☐ Yes ☐ No Is the patient being treated for HER2-positive recurrent or metastatic breast cancer?

→ Please indicate which applies: ☐ Recurrent breast cancer ☐ Metastatic breast cancer

☐ Yes ☐ No Does the patient have symptomatic visceral disease or visceral crisis?
If yes, please specify: ☐ symptomatic visceral disease ☐ Visceral crisis

→ Please indicate the type of breast cancer: ☐ Hormone receptor- negative ☐ Hormone receptor- positive
☐ Other: _____

☐ Yes ☐ No Is the breast cancer refractory to endocrine therapy?

☐ Yes ☐ No Will Kadcyla (ado-trastuzumab emtansine) be used as a single agent?

☐ Yes ☐ No Will Kadcyla (ado-trastuzumab emtansine) be used in the adjuvant setting?

☐ Yes ☐ No Will Kadcyla (ado-trastuzumab emtansine) be used concomitantly with Herceptin (trastuzumab), Tykerb (lapatinib), or Perjeta (pertuzumab)?

For Continuation Requests:

☐ Yes ☐ No Has the patient experienced disease progression or unacceptable toxicity while on HER2 therapy?

→ Please indicate: ☐ Disease progression ☐ Unacceptable toxicity

HERCEPTIN (trastuzumab):

For HER2-positive breast cancer only:

☐ Yes ☐ No Is there clinical evidence of distant metastatic disease?

→ Please provide initial start date: ____/____/____

PERJETA (pertuzumab) with HERCEPTIN (trastuzumab):

☐ Yes ☐ No Is there clinical evidence of distant metastatic disease?

→ Please provide initial start date: ____/____/____

KADCYLA (ado-trastuzumab emtansine):

☐ Yes ☐ No Is Kadcyla (ado-trastuzumab emtansine) being used in the adjuvant setting?

☐ Yes ☐ No Is Kadcyla (ado-trastuzumab emtansine) being used concomitantly with Herceptin (trastuzumab), Tykerb (lapatinib), or Perjeta (pertuzumab)?

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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.