



# Kanjinti™ (trastuzumab-anns) 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:	
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 #:	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> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ Address: _____ <input type="checkbox"/> Administration code(s) (CPT): _____	<b>Dispensing Provider/Pharmacy:</b> <i>Patient Selected choice</i> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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### E. PRODUCT INFORMATION

**Request is for:**  Kanjinti (trastuzumab-anns) **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):**  
What is the human epidermal growth factor receptor 2 (HER2) status?  HER2 positive  HER2 negative  Unknown  
**ACTION REQUIRED:** Please attach documentation of human epidermal growth factor receptor 2 (HER2) status.

**Breast cancer**  
 Yes  No Will the requested drug be used for the intra-cerebrospinal fluid (CSF) treatment for leptomeningeal metastases from breast cancer?  
→ In what clinical setting will the requested drug be used?  
 Adjuvant therapy  
→  Yes  No Has the patient received the requested drug for 12 months (52 weeks) or greater as adjuvant therapy?  
 Preoperative (neoadjuvant) therapy  
→  Yes  No Will the requested drug be used as part of a complete treatment regimen?  
 Yes  No Has the patient received the requested drug for 12 months (52 weeks) or greater as adjuvant therapy?  
 Treatment of recurrent or metastatic disease  
 Other (please specify) \_\_\_\_\_

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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.

**Colorectal Cancer**

- Yes  No Does the patient have HER2- amplified and RAS wild-type disease?
- Yes  No Will the requested drug be used in combination with pertuzumab or lapatinib?
- Yes  No Is the patient appropriate for intensive therapy?
- Yes  No Will trastuzumab be used as subsequent therapy for disease progression?
- Does the patient have advanced or metastatic disease?  Advanced disease  Metastatic Disease

Esophageal cancer  Gastric cancer  Gastroesophageal Junction cancer

- Yes  No Will the requested medication be used in combination with chemotherapy?
- Yes  No Please provide the name of the systemic chemotherapy: \_\_\_\_\_

**Salivary gland tumors**

- Yes  No Does the patient have recurrent disease?
- Yes  No Does the patient have distant metastases?

**Uterine Serous Sarcoma**

- Yes  No Will the requested drug be used in combination with carboplatin and paclitaxel?
- Does the patient have advanced or recurrent disease?  Advanced disease  Recurrent Disease  Other: Please explain: \_\_\_\_\_

**For Continuation Requests (clinical documentation required):**

- Yes  No Has the patient experienced disease progression or unacceptable toxicity while on HER2 therapy?
- Yes  No Please indicate:  Disease progression  Unacceptable toxicity
- Yes  No Is the requested drug being used as adjuvant/neoadjuvant treatment of breast cancer?
- Yes  No How many months of the requested medication has the patient received?
- Please provide initial start date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**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.