aetna®

Lartruvo™ (olaratumab) 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 #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ 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** ☐ **Hematologist** ☐ **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 Lartruvo (olaratumab): 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 Will Lartruvo (olaratumab) be given in combination with doxorubicin?

☐ **Soft tissue sarcoma**
Please select the type of soft tissue sarcoma that applies to the patient:
☐ **Angiosarcoma**
☐ **Intraabdominal soft tissue sarcoma** ☐ **Retroperitoneal soft tissue sarcoma**
Please indicate which of the following settings applies to the patient:
☐ Preoperative chemotherapy
→ ☐ Yes ☐ No Is the preoperative chemotherapy for resectable disease?
☐ Primary chemotherapy
→ ☐ Yes ☐ No Is the primary chemotherapy for attempted down staging?
→ Please indicate which of the following disease states apply to the patient:
Please select: ☐ Unresectable disease ☐ Recurrent disease ☐ Metastatic disease
☐ Chemoradiation
→ ☐ Yes ☐ No Is the chemoradiation for attempted down staging?
→ Please indicate which of the following disease states apply to the patient:
Please select: ☐ Unresectable disease ☐ Recurrent disease ☐ Metastatic disease

Continued on next page

aetna®

Lartruvo™ (olaratumab) 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

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION (*continued*) - Required clinical information must be completed for ALL precertification requests.

☐ **Soft tissue sarcoma**

☐ **Intraabdominal soft tissue sarcoma** ☐ **Retroperitoneal soft tissue sarcoma**

→ ☐ Palliative therapy

☐ Yes ☐ No Does the patient have unresectable or progressive disease?
Please select: ☐ Unresectable disease ☐ Progressive disease

☐ **Rhabdomyosarcoma**

☐ Yes ☐ No Is the patient being treated for pleomorphic rhabdomyosarcoma?

☐ **Soft tissue sarcoma of the extremity, head, neck, superficial trunk**

Please select which of the following is affected: ☐ Extremity ☐ Head ☐ Neck ☐ Superficial trunk

Please indicate which of the following therapies apply to the patient:

☐ **Adjuvant chemotherapy**

Please select the patient's disease stage: ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Unknown

Please select which applies to the patient's tumor(s)? ☐ Unresectable ☐ Resectable with acceptable functional outcomes ☐ Resectable with adverse functional outcomes ☐ Unknown

☐ Yes ☐ No Is this request for primary tumors or local recurrence?
→ Please select: ☐ Primary tumors ☐ Local recurrence

☐ **Chemotherapy following reginal node dissection**

☐ **Palliative chemotherapy**

☐ Yes ☐ No Is this palliative chemotherapy for synchronous stage IV disease or recurrent disease?
→ Please select: ☐ Synchronous stage IV disease ☐ Recurrent disease

☐ Yes ☐ No Does the patient have disseminated metastases?

☐ Yes ☐ No Is an anthracycline-containing regimen appropriate?

☐ **Preoperative treatment**

☐ Yes ☐ No Is this request for preoperative chemotherapy or chemoradiation?
→ Please select: ☐ Preoperative chemotherapy ☐ Preoperative chemoradiation

Please select the patient's disease stage: ☐ Stage I ☐ Stage IIA ☐ Stage IIB ☐ Stage III ☐ Stage IV ☐ Unknown

Please select which applies to the patient's tumor(s)? ☐ Unresectable ☐ Resectable with acceptable functional outcomes ☐ Resectable with adverse functional outcomes ☐ Unknown

☐ Yes ☐ No Is this request for primary tumors or local recurrence? ☐ Primary tumors ☐ Local recurrence

☐ **Primary treatment**

☐ Yes ☐ No Is this primary treatment as chemotherapy or chemoradiation?
→ Please select: ☐ Chemotherapy ☐ Chemoradiation

Please select the patient's disease stage: ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Unknown

Please select which applies to the patient's tumor(s)? ☐ Unresectable ☐ Resectable with acceptable functional outcomes ☐ Resectable with adverse functional outcomes ☐ Unknown

☐ Yes ☐ No Is this request for primary tumors or local recurrence? ☐ Primary tumors ☐ Local

☐ **Treatment before or after metastasectomy**

Please indicate if treatment is before or after metastasectomy: ☐ Before metastasectomy ☐ After metastasectomy

Please select which of the following disease states apply to the patient:

☐ Single-organ confined ☐ Limited tumor bulk synchronous stage IV ☐ Isolated regional lymph nodes
☐ Recurrent disease that is amenable to local therapy ☐ Recurrent isolated regional disease

Continued on next page

aetna®

Lartruvo™ (olaratumab) 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

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION (*continued*) - Required clinical information must be completed for ALL precertification requests.

☐ **Uterine sarcoma**

☐ Yes ☐ No Will the patient be receiving treatment for disease that is not suitable for primary surgery?

→ ☐ Yes ☐ No Will the patient be receiving treatment following total hysterectomy with or without bilateral salpingo-oophorectomy (TH ± BSO)?

→ ☐ Yes ☐ No Will the patient be receiving treatment for a radiologically isolated vaginal/pelvic recurrence?

→ ☐ Yes ☐ No Will the patient be receiving treatment for isolated metastases?

→ ☐ Yes ☐ No Will the patient be receiving treatment for disseminated metastases?

→ Please select: ☐ Vaginal recurrence ☐ Pelvic recurrence

Please select: ☐ TH with BSO ☐ TH without BSO

Please select the patient's disease stage: ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

☐ Unknown

→ ☐ Yes ☐ No Will the patient be receiving treatment for radiologically isolated vaginal/pelvic recurrence?

→ ☐ Yes ☐ No Will the patient be receiving treatment for isolated metastases?

→ ☐ Yes ☐ No Will the patient be receiving treatment for isolated metastases?

→ ☐ Yes ☐ No Will the patient be receiving treatment for disseminated metastases?

→ Please select: ☐ Vaginal recurrence ☐ Pelvic recurrence

For Continuation Requests:

☐ Yes ☐ No Is there evidence of disease progression or unacceptable toxicity?

→ ☐ Yes, disease progression ☐ Yes, unacceptable 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.