Levoleucovorin (Fusilev®, Khapzory™) 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:	E-mail:
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms		Allergies:	

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 ☐ **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 ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ Fusilev (levoleucovorin) or its generic equivalent ☐ Khapzory (levoleucovorin)
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 (clinical documentation required for all requests):

☐ Yes ☐ No Is leucovorin unable to be obtained due to a documented drug shortage?
☐ Yes ☐ No Has the drug shortage been confirmed via the US Food and Drug Administration's Drug Shortages Index?
→ Please indicate the date the US Food and Drug Administration Drug Shortage Index was verified: Date ____/____/____
☐ Yes ☐ No Will levoleucovorin (Fusilev or Khapzory) be used in combination with fluorouracil-based regimens?
→ **Please select the diagnosis from below:**

☐ Anal adenocarcinoma ☐ Appendiceal carcinoma ☐ Cervical adenocarcinoma ☐ Colorectal adenocarcinoma
☐ Esophageal and esophagogastric junction (i.e. squamous cell carcinoma, adenocarcinoma) ☐ Gastric adenocarcinoma
☐ Hepatocellular adenocarcinoma ☐ Neuroendocrine and adrenal tumors (i.e., poorly differentiated (high grade); large or small cell)
☐ Occult primary (cancer of unknown primary [CUP]) adenocarcinoma, carcinoma not otherwise specified, or squamous cell carcinoma
☐ Ovarian mucinous carcinoma ☐ Pancreatic adenocarcinoma ☐ Pure adenocarcinoma of the urinary bladder including urachal
☐ Small bowel adenocarcinoma ☐ Squamous cell carcinoma ☐ Thymic carcinoma or thymoma

Continued on next page.

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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 levoleucovorin (Fusilev or Khapzory) be used as a component of a high-dose methotrexate regimen?

→ **Please select the diagnosis from below:**

☐ Acute lymphoblastic leukemia ☐ Brain metastases ☐ B-cell lymphomas ☐ Dedifferentiated chondrosarcoma
☐ Gestational trophoblastic neoplasia ☐ High-grade undifferentiated pleomorphic sarcoma (UPS) ☐ Leptomeningeal metastases
☐ Osteosarcoma ☐ Primary central nervous system lymphoma ☐ T-cell lymphomas

☐ For none listed above:

→ ☐ Yes ☐ No Will levoleucovorin (Fusilev or Khapzory) be used to diminish the toxicity and counteract the effects of impaired methotrexate elimination?

☐ Yes ☐ No Will levoleucovorin (Fusilev or Khapzory) be used to diminish the toxicity and counteract the effects of inadvertent over- dosage of folic acid antagonists?

For Khapzory (levoleucovorin) request only:

☐ Yes ☐ No Has the patient had ineffective response, intolerance, or contraindication to Fusilev or its generic equivalent?

→ Please explain: ☐ ineffective response ☐ intolerance ☐ contraindication

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.