Ogivri™ (trastuzumab-dkst) Precertification Request

(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 #: _____
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 ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Ogivri (trastuzumab-dkst)** **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.

☐ Yes ☐ No Has the patient had a contraindication, intolerance or ineffective response to Herceptin?
→ Please identify: ☐ Contraindication ☐ Intolerance ☐ Ineffective response

☐ Yes ☐ No Has the patient had a contraindication, intolerance or ineffective response to Kanjinti?
→ Please identify: ☐ Contraindication ☐ Intolerance ☐ Ineffective response

☐ Yes ☐ No Has the patient had a contraindication, intolerance or ineffective response to Trazimera?
→ Please identify: ☐ Contraindication ☐ Intolerance ☐ Ineffective response

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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.

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) _____

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?
→ 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?
→ Please indicate: ☐ Disease progression ☐ Unacceptable toxicity
☐ Yes ☐ No Is the requested drug being used as adjuvant/neoadjuvant treatment of breast cancer?
→ 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.