Polivy (polatuzumab vedotin-piiq) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-752-7021
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:	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 #: ______________
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** ☐ **Internist** ☐ **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: ______________
Phone: ______________ Fax: ______________
Address: ______________
TIN: ______________ PIN: ______________

E. PRODUCT INFORMATION

Request is for ☐ **Polivy (polatuzumab vedotin-piiq): 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):

Please indicate the patient's documented diagnosis: ☐ Diffuse large B-cell lymphoma
☐ High grade B-cell lymphoma
→ ☐ Yes ☐ No Does the patient have translocations of MYC and BCL2 and/or BCL6 as detected by FISH or standard cytogenetics?
☐ Other-Please explain: ______________

Please indicate how many cycles of chemotherapy containing Polivy (polatuzumab vedotin-piiq) are planned: ______________

☐ Yes ☐ No Will Polivy (polatuzumab vedotin-piiq) be used as second-line or subsequent therapy?
→ ☐ Second-line therapy ☐ Subsequent therapy

☐ Yes ☐ No Has the patient received at least two prior therapies?
→ Please indicate the response to the previous therapies: ☐ Partial response ☐ No response ☐ Disease relapsed ☐ Disease is refractory ☐ Disease progression ☐ None of the above

☐ Yes ☐ No Will Polivy (polatuzumab vedotin-piiq) be used in combination with bendamustine and a rituximab product?
☐ Yes ☐ No Is the patient a candidate for transplant?

For Continuation of therapy requests (clinical documentation required for all requests):

☐ Yes ☐ No How many cycles of Polivy (polatuzumab vedotin-piiq) has the patient received in a lifetime? ______________
☐ Yes ☐ No Has the patient experienced disease progression?
☐ Yes ☐ No Has the patient experienced unacceptable toxicity?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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.