aetna®

Provenge® (Sipuleucel-T) 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:		
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 #: _____
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** ☐ **Urologist** ☐ **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): _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Provenge: 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.

☐ Yes ☐ No Does the patient have histological confirmed adenocarcinoma of the prostate?
☐ Yes ☐ No Is there clinical evidence of radiologic confirmation of metastases to soft tissue?
☐ Yes ☐ No Is there clinical evidence of radiologic confirmation of metastases to lymph nodes?
☐ Yes ☐ No Is there clinical evidence of radiologic confirmation of metastases to bone?
☐ Yes ☐ No Has the patient been treated with surgical (bilateral orchiectomy) castration?
→ Please indicate the date of the surgery: ____/____/____
☐ Yes ☐ No Has the patient been treated with chemical castration (luteinizing hormone releasing hormone (LHRH) agonists or antagonists)?
→ Please indicate the medication used: ☐ leuprolide (Lupron, Visdur, Eligard) ☐ goserelin (Zoladex) ☐ triptorelin (Trelstar)
☐ histrelin (Vantas) ☐ degarelix (Firmagon) ☐ Other: _____
Please indicate the date range of medication therapy: ____/____/____ to ____/____/____
Please specify the patient's serum testosterone concentration level and date drawn: _____ ng/dL Date: ____/____/____
Please indicate the time frame the testosterone concentration level was obtained:
☐ Current Level ☐ At initiation of chemical castration ☐ Other: _____
☐ Yes ☐ No Does the patient have clinical evidence of progressive disease after receiving surgical or chemical castration (known as castrate-resistant, hormone-refractory, or androgen-independent prostate cancer?
→ Please indicate the evidence determining disease progression:
☐ Progressive measurable disease
Please specify: ☐ Changes in size of lymph nodes
☐ Parenchymal masses on physical examination
☐ Radiographic studies: Please enter dates of radiographs: ____/____/____ , ____/____/____
☐ Other: _____

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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.

☐ Worsening disease on bone scan
Please indicate date of bone scan: ____/____/____
Please specify the progression found on bone scan:
☐ 1 or more new lesions
☐ Increase in size of lesion
☐ Other: _____
☐ Yes ☐ No Were the new lesions or increase in size of lesions documented at commencement of hormonal therapy or chemotherapy?

☐ Increasing prostate-specific antigen (PSA)
☐ Yes ☐ No Was there an increase in PSA over a previous reference value?
Please indicate the patient's previous reference PSA value and date taken: _____ ng/mL Date: ____/____/____
Please indicate the patient's most current PSA and date taken: _____ ng/mL Date: ____/____/____
The percentage difference between the reference value and current value is ☐ 24% or less ☐ 25% or greater
☐ Yes ☐ No Was a second PSA drawn to confirm the result?
→ Please indicate the PSA level and date drawn: _____ ng/mL Date: ____/____/____

What is the patient's ECOG Performance Status: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Please indicate the patient's life expectancy: ☐ 0-5 months ☐ 6 months or greater
☐ Yes ☐ No Is the patient asymptomatic or minimally symptomatic? ☐ Asymptomatic ☐ Symptomatic
☐ Yes ☐ No Is the patient without cancer-related bone pain?
☐ Yes ☐ No Is the patient taking opioid analgesics for cancer pain?
☐ Yes ☐ No Is there clinical evidence of liver metastases?
☐ Yes ☐ No Will Provenge be used in combination with Xtandi (enzalutimide) or Zytiga (abiraterone)?
→ Please identify which drug Provenge will be used in combination with: ☐ Xtandi (enzalutimide) ☐ Zytiga (abiraterone)
☐ Yes ☐ No Has the patient previously received any doses of Provenge?
→ Please indicate all dates of infusion(s): ____/____/____ , ____/____/____ , ____/____/____

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.