aetna®

Xofigo® (radium RA 223 dichloride) 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:
Current Weight: _____ lbs or _____ kgs 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: ☐ Radiation 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 ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for ☐ **Xofigo 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 Has the patient been diagnosed with histologically confirmed metastatic castration- resistant prostate cancer (mCRPC)?

☐ Yes ☐ No Did the patient undergo surgical (bilateral orchiectomy) castration?
→ Please indicate the date of surgery: ____/____/____

☐ Yes ☐ No Did the patient undergo chemical castration?
→ Please indicate the medications used and dates: _____ Dates: ____/____/____ - ____/____/____

☐ Yes ☐ No Does the patient have clinical evidence of metastasis from prostate cancer?
→ Please indicate where the cancer has spread: ☐ Brain ☐ Bones ☐ Lymph nodes ☐ Lungs ☐ Liver ☐ Other - please explain: _____

For Initial Requests:

Please indicate the patient's pre-treatment absolute neutrophil count and date obtained: _____x10(9)/L Date: ____/____/____
Please indicate the patient's pre-treatment platelet count and date obtained: _____x10(9)/L Date: ____/____/____
Please indicate the patient's pre-treatment hemoglobin count and date obtained: _____x10(9)/L Date: ____/____/____

☐ Yes ☐ No Is the patient symptomatic?

For Continuation Requests:

☐ Yes ☐ No Has the patient experienced significant disease progression while on Xofigo?
→ Please explain: ☐ Locoregional metastasis ☐ Distant nodal metastasis ☐ Soft tissue metastasis ☐ Lung metastasis
☐ Visceral metastasis other than lung (e.g. liver, brain, bone) ☐ Other - please explain: _____

Please indicate the patient's current absolute neutrophil count and date obtained: _____x10(9)/L Date: ____/____/____
Please indicate the patient's current platelet count and date obtained: _____x10(9)/L Date: ____/____/____
Please provide the date the patient began therapy: ____/____/____

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.