aetna®

Asfotase alfa (Strensiq) 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 #: _____ 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)*: ☐ **Metabolic Specialist** ☐ **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 Strensiq: 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:
Please provide the patient's weight in kg: _____
☐ Yes ☐ No Does the patient have a documented diagnosis of hypophosphatasia (HPP)?
→ Please indicate the type of HPP the patient has been diagnosed with and answer the corresponding questions: **(must submit records/labs with request)**

☐ Perinatal (lethal)
The diagnosis has been confirmed by: ☐ Prenatal ultrasound findings ☐ Radiographs
Please enter date of radiograph or ultrasound: ____/____/____

☐ Perinatal (benign)
The diagnosis has been confirmed by: ☐ Clinical course ☐ Prenatal ultrasound exam
Please enter date of ultrasound or describe clinical findings: _____

☐ Infantile
The diagnosis has been confirmed by: ☐ Clinical course ☐ Laboratory findings ☐ Radiographs
Please enter date of radiograph or describe clinical or laboratory findings: _____

☐ Juvenile/Childhood
The diagnosis has been confirmed by: ☐ Clinical course ☐ Laboratory findings ☐ Radiographs
Please enter date of radiograph or describe clinical or laboratory findings: _____

☐ Other, please select: ☐ Adult HPP ☐ Odontohypophosphatasia ☐ Pseudohypophoshatasia

What age is the patient's documented onset of signs/symptoms of HPP? _____
☐ Yes ☐ No Does the patient have documented tissue-non-specific alkaline phosphatase (TNSALP) gene mutation?
☐ Yes ☐ No Has the patient had a laboratory test indicating a serum alkaline phosphatase (ALP) level below the age-adjusted normal range?
→ Please provide the ALP level and date obtained: _____ IU/L Date: ____/____/____

Continued on next page

aetna®

Asfotase alfa (Strensiq) 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

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 Has the patient had a laboratory test indicating a plasma pyridoxal-5'-phosphate (PLP) above the upper limit of normal?
→ Please provide the PLP level and date obtained: _____ mcg/L Date: ____/____/____
☐ Yes ☐ No Was the PLP level drawn while the patient was receiving pyridoxine treatment?

☐ Yes ☐ No Has the patient had a baseline ophthalmologic examination?
→ Please provide the date of the eye exam: ____/____/____

☐ Yes ☐ No Has the patient had a baseline renal ultrasound?
→ Please provide the date of the ultrasound: ____/____/____

For Continuation Requests:

☐ Yes ☐ No Has the patient been monitored for ectopic calcifications (eye and kidneys) during treatment?
→ Please provide the date of the patient's last ophthalmologic exam: ____/____/____
→ Please provide the date of the patient's last renal ultrasound: ____/____/____

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.