aetna®

Ziv-Aflibercept (Zaltrap®) 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 #: _____
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** ☐ Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ 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 Zaltrap: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ ☐ Other: _____ * Please attach rationale

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For ALL requests:
Please indicate the diagnosis that the patient will be treated for:
☐ Advanced colorectal cancer ☐ Appendiceal adenocarcinoma ☐ Anal adenocarcinoma
☐ Metastatic colorectal cancer ☐ Small intestine adenocarcinoma ☐ Other: _____
☐ Yes ☐ No Will Zaltrap be used in combination with irinotecan?
☐ Yes ☐ No Will Zaltrap be used in combination with FOLFIRI (leucovorin), fluorouracil, and irinotecan) chemotherapy?
☐ Yes ☐ No Will Zaltrap be used in combination with bevacizumab (Avastin)?

For Initial requests:
☐ Yes ☐ No Will Zaltrap be used as subsequent therapy after first progression of unresectable advanced or metastatic disease?
→ ☐ Yes ☐ No Has the patient previously received an irinotecan-based regimen?
☐ Yes ☐ No Will Zaltrap be used to treat unresectable metachronous metastases?
→ ☐ Yes ☐ No Has the patient been previously treated with adjuvant FOLFOX (leucovorin), fluorouracil, and oxaliplatin) therapy? ***If yes***, please indicate date range of therapy: ____/____/____ - ____/____/____
☐ Yes ☐ No Has the patient been previously treated with adjuvant CapeOX (capecitabine and oxaliplatin) therapy?
If yes, please indicate date range of therapy: ____/____/____ - ____/____/____
☐ Yes ☐ No Does the patient have metastatic colorectal cancer that is resistant or has progressed following an oxaliplatin-containing regimen?

For Continuation requests:
☐ Yes ☐ No Has the patient experienced significant disease progression while on Zaltrap?
→ Please indicate the disease progression that occurred while on Zaltrap:
☐ Primary tumor progression ☐ Regional lymph node metastasis ☐ Distant metastasis ☐ Other:_____

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.