



**Bendamustine
(Treanda®, Bendeka®, Belrapzo™)
Medication Precertification Request**

Page 1 of 3

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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:	
Email:		Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms Allergies:			

B. INSURANCE INFORMATION

Aetna Member ID #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:		State: ZIP:
Phone:		Fax:		St Lic #: NPI #: DEA #: UPIN:	
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: Patient Selected choice	
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy	
<input type="checkbox"/> Outpatient Infusion Center Phone: _____		<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____	
Center Name: _____		Name: _____	
<input type="checkbox"/> Home Infusion Center Phone: _____		Address: _____	
Agency Name: _____		Phone: _____ Fax: _____	
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____ PIN: _____	
Address: _____			

E. PRODUCT INFORMATION

Request is for: Treanda Bendeka Belrapzo
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 Initiation Requests (Clinical documentation required for all requests):

AIDS-related B-cell lymphoma
 Yes No Will the requested drug be used as subsequent therapy?
 Yes No Will the requested drug be used as a bridging option until CAR T-cell product is available?
 Yes No Is the patient a candidate for transplant?

Adult T-cell leukemia/lymphoma (ATLL)
 Yes No Will the requested drug be used as a single agent?
 Yes No Will the requested drug be used as subsequent therapy?

Breast implant associated anaplastic large cell lymphoma (ALCL)
 Yes No Will the requested drug be used as a single agent?
 Yes No Will the requested drug be used as subsequent therapy?

Chronic lymphocytic leukemia (CLL) without chromosome 17p deletion or without TP53 mutation

Classical Hodgkin lymphoma
 Yes No Will the requested drug be used as subsequent therapy or palliative therapy?
Please indicate the requested regimen:
 The requested drug will be used as a single agent
 The requested drug will be used in combination with brentuximab vedotin (Adcetris)
 The requested drug will be used in combination with gemcitabine and vinorelbine
 The requested drug will be used in combination with carboplatin and etoposide
 None of the above

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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Cutaneous anaplastic large cell lymphoma (ALCL)
 Yes No Will the requested drug be used as a single agent?
 Yes No Is the disease relapsed or refractory?

Diffuse large B-cell lymphoma (DLBCL)
 Yes No Will the requested drug be used as subsequent therapy?
 Yes No Will the requested drug be used as a bridging option until CAR T-cell product is available?
 ↳ Yes No Is the patient a candidate for transplant?
 Please indicate the requested regimen:
 The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy)
 The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy) and rituximab
 None of the above

Follicular lymphoma

Hepatosplenic T-Cell Lymphoma
 Yes No Will the requested drug be used as a single agent?
 Yes No Is the disease refractory?

High grade B-cell lymphoma
 Yes No Will the requested drug be used as subsequent therapy?
 Yes No Will the requested drug be used as a bridging option until CAR T-cell product is available?
 ↳ Yes No Is the patient a candidate for transplant?

Histologic transformation of follicular lymphoma to diffuse large B-cell lymphoma without translocations of MYC and BCL2 and/or BCL6
 Please indicate the requested regimen:
 The requested drug will be used as a single agent
 The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy)
 The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy) and rituximab
 None of the above
 Yes No Will the requested drug be used as subsequent therapy?

Histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma
 Please indicate how many lines of chemoimmunotherapy the patient has received: _____
 Please indicate the requested regimen:
 The requested drug will be used as a single agent
 The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy)
 The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy) and rituximab
 The requested drug will be used in combination with rituximab
 None of the above

Mantle cell lymphoma (MCL)
 Please indicate the requested regimen:
 The requested drug will be used in combination with rituximab
 The requested drug will be used as a component of RBAC500 (rituximab, bendamustine, and cytarabine)
 None of the above

Marginal zone lymphoma (nodal, gastric MALT, non-gastric MALT, splenic)
 Please indicate the requested regimen:
 The requested drug will be used in combination with rituximab
 The requested drug will be used in combination with obinutuzumab (Gazyva)
 None of the above

Multiple myeloma
 Please indicate the requested regimen:
 The requested drug will be used as a single agent
 The requested drug will be used in combination with lenalidomide (Revlimid) and dexamethasone
 The requested drug will be used in combination with bortezomib (Velcade) and dexamethasone
 None of the above
 Yes No Is the disease relapsed or progressive?

Mycosis fungoides (MF)

Nodular Lymphocyte Predominant Hodgkin lymphoma (NLPHL)
 Yes No Will the requested drug be used as subsequent therapy?
 Yes No Will the requested drug be used in combination with rituximab?

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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Post-transplant lymphoproliferative disorders

Yes No Will the requested medication be used as a bridging option until CAR T-cell product is available?

→ Yes No Is the patient a candidate for transplant?

Yes No Will the requested drug be used as subsequent therapy?

Please indicate the requested regimen:

- The requested drug will be used as a single agent
- The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy)
- The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy) and rituximab
- The requested drug will be used in combination with rituximab
- None of the above

Peripheral T-cell Lymphoma (PTCL) [including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, or follicular T-cell lymphoma]

Yes No Will the requested drug be used as a single agent?

Yes No Will the requested drug be used as palliative or subsequent therapy?

Sezary syndrome (SS)

Small lymphocytic lymphoma (SLL) without chromosome 17p deletion or without TP53 mutation

Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma

Please indicate the requested regimen:

- The requested drug will be used as a single agent
- The requested drug will be used in combination with rituximab
- None of the above

For Continuation Requests (clinical documentation required for all requests):

Yes No Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

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.