



Besponsa® (inotuzumab ozogamicin) Medication Precertification Request

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(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:

Phone: 1-866-503-0857

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:	Email:	
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms	

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

Request is for Besponsa (inotuzumab ozogamicin): 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 (clinical documentation required):
 Yes No Does the patient have a documented diagnosis of acute lymphoblastic leukemia (ALL)?

For Initiation Requests (Clinical documentation required):
 Yes No Is there documentation that the patient has B-cell precursor acute lymphoblastic leukemia (B-ALL)?
 Yes No Does the patient have relapsed or refractory disease?
→ Please explain: Relapsed Refractory
 Yes No Unknown Is the tumor CD-22 positive as confirmed by testing or analysis to identify the CD22 protein on the surface of the B-cell?
Please indicate the Philadelphia chromosome status of the patient's disease:
 Philadelphia chromosome-positive (Ph+) disease
→ Yes No Is the patient intolerant or refractory to tyrosine kinase inhibitor therapy (e.g., imatinib (Gleevec), dasatinib (Sprycel), nilotinib, (Tasigna), bosutinib (Bosulif), ponatinib (Iclusig))?
→ Intolerant Refractory Unknown
 Philadelphia chromosome-negative (Ph-) disease
 Unknown

Please indicate the requested regimen:
 Single agent In combination with cyclophosphamide, dexamethasone, vincristine, methotrexate, and cytarabine
 In combination with bosutinib
 Other, please explain: _____
 Yes No Will the patient receive more than 6 treatment cycles of the requested drug?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

For Continuation Requests (clinical documentation required):

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

Please indicate the number of cycles the patient has already received: _____

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.