CAMCEVI® (leuprolide) Medication Precertification Request

(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:	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 #: ____________
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 Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **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 ☐ Other

Name: ____________
Address: ____________
Phone: ____________ Fax: ____________
TIN: ____________ PIN: ____________

E. PRODUCT INFORMATION

Request is for: CAMCEVI (leuprolide) 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 diagnosis of prostate cancer?

For Initiation Requests (clinical documentation required):

Please indicate the clinical setting in which the requested drug will be used: ☐ Advanced disease ☐ Other

Please indicate the preferred alternatives for prostate cancer that have been ineffective, not tolerated, or are contraindicated: ☐ Eligard ☐ Firmagon

☐ Yes ☐ No Has the patient failed treatment with Eligard and Firmagon due to a documented intolerable adverse event (e.g., rash, nausea, vomiting)?
→ ☐ Yes ☐ No Was the adverse event unexpected and not attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the brand and biosimilar medication)?

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Has the patient experienced clinical benefit while receiving the requested drug (e.g., serum testosterone less than 50 ng/dL)?
☐ Yes ☐ No Is there evidence of unacceptable toxicity 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.