



FYARRO™ (sirolimus protein-bound particles for injectable suspension) (albumin-bound) Medication Precertification Request

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

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

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: FYARRO (sirolimus protein-bound particles for injectable suspension) (albumin-bound)
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 malignant perivascular epithelioid cell tumor (PEComa)?

For Initiation Requests (clinical documentation required):
Please indicate the clinical setting in which the requested drug will be used:
 Locally advanced unresectable disease Metastatic disease Other

For Continuation Requests (clinical documentation required):
 Yes No Is there evidence of unacceptable toxicity or disease progression 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.