Hemgenix® (etranacogene dezaparvovec-drlb) 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:
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 #: ______________________
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)*: ☐ **Hematologist** ☐ **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: Hemgenix (etranacogene dezaparvovec-drlb) 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 Hemophilia B (congenital Factor IX deficiency)?
☐ Yes ☐ No Will the requested medication be prescribed by or in consultation with a hematologist?
☐ Yes ☐ No Does the patient have a negative Factor IX inhibitor test result within the past 30 days?
→ ☐ Yes ☐ No Does the patient have a positive Factor IX inhibitor test result within the past 30 days, followed by a negative test result within two weeks of the initial positive result?
☐ Yes ☐ No Has the patient previously received gene therapy treatment?
☐ Yes ☐ No Does the patient have severe or moderately severe Factor IX deficiency (≤2% of normal circulating Factor IX)?
☐ Yes ☐ No Is the patient currently using Factor IX prophylactic therapy?
☐ Yes ☐ No Does the patient have a current or a history of a life-threatening hemorrhage?
☐ Yes ☐ No Does the patient have a history of repeated, serious spontaneous bleeding episodes?

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.