# Herceptin® and Trastuzumab Biosimilars 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: | | |
| 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 #**: _____
**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: _____
Address: _____
☐ Administration code(s) (CPT): _____

**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:** ☐ **Herceptin (trastuzumab)** ☐ **Herzuma (trastuzumab-pkrb)** ☐ **Kanjinti (trastuzumab-anns)** ☐ **Ogivri (trastuzumab-dkst),** ☐ **Ontruzant (trastuzmab-dttb)** ☐ **Trazimera (trastuzumab-qyyp)**

**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.

☐ Yes ☐ No Is this request for Herceptin (trastuzumab), Herzuma (traztuzumab-pkrb), Trazimera (trastuzumab-qyyp), or Ontruzant (trastuzmab-dttb)?
→ ☐ Yes ☐ No Has the patient tried and failed treatment with Kanjinti (trastuzumab-anns) and Ogivri trastuzumab-dkst) 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?

**For Initiation Requests (clinical documentation required):**
What is the human epidermal growth factor receptor 2 (HER2) status? ☐ HER2 positive ☐ HER2 negative ☐ Unknown

☐ **Breast cancer**
Please indicate the clinical setting in which the requested drug will be used:
☐ Adjuvant therapy
→ How many months has the patient received therapy with the requested medication? ____
☐ Preoperative (neoadjuvant) therapy
→ ☐ Yes ☐ No Will the requested drug be used as part of a complete treatment regimen?
How many months has the patient received therapy with the requested medication? ____

***Continued on next page***

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

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

- ☐ Treatment of recurrent, advanced unresectable, or metastatic disease (including brain metastases)
- ☐ Intra-cerebrospinal fluid (CSF) treatment for leptomeningeal metastases from breast cancer
- ☐ Other (please specify): _____

☐ **Colorectal cancer**

- ☐ Yes ☐ No ☐ Unknown Does the patient have HER2- amplified disease?
- ☐ Yes ☐ No ☐ Unknown Does the patient have RAS and BRAF wild-type disease?
- ☐ Yes ☐ No Will the requested drug be used in combination with pertuzumab or lapatinib?
- ☐ Yes ☐ No Will the requested drug be used as subsequent therapy for progression of advanced or metastatic disease?
  - → ☐ Yes ☐ No Is the patient appropriate for intensive therapy?

☐ **Esophageal cancer** ☐ **Gastric cancer** ☐ **Gastroesophageal Junction cancer**

- ☐ Yes ☐ No Will the requested medication be used in combination with chemotherapy?

☐ **Salivary gland tumors**

☐ **Uterine serous carcinoma**

- ☐ Yes ☐ No Will the requested drug be used in combination with carboplatin and paclitaxel?
- ☐ Yes ☐ No Does the patient have advanced, recurrent, or metastatic disease?
  - → Please explain: ☐ advanced disease ☐ recurrent disease ☐ metastatic disease

**For Continuation Requests (clinical documentation required):**

- ☐ Yes ☐ No Has the patient experienced disease progression or unacceptable toxicity while on the current regimen?
- ☐ Yes ☐ No Is the requested drug being used as adjuvant/neoadjuvant treatment of breast cancer?
  - → How many months of the requested medication has the patient 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.