



# Kadcyla<sup>®</sup> (ado-trastuzumab) 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:	E-mail:	
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 E-mail:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Other: _____					

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <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: _____ Address: _____ <input type="checkbox"/> Administration code(s) (CPT): _____	<b>Dispensing Provider/Pharmacy: Patient Selected choice</b> <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:**  Kadcyla (ado-trastuzumab emtansine)  
**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):**  
What is the human epidermal growth factor receptor 2 (HER2) status?  HER2 positive  HER2 negative  Unknown

**Breast cancer**  
 Yes  No Does the patient have early breast cancer?  
 Yes  No Does the patient have recurrent or metastatic breast cancer?  
 Yes  No Will the requested drug be used as adjuvant treatment of residual disease after neoadjuvant taxane and trastuzumab-based treatment?

**Non-small cell lung cancer**  
 **Salivary gland tumor**  
Please indicate the clinical setting in which the requested drug will be used:  recurrent disease  other  
 Yes  No Will the requested drug be used as a single agent?

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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 Has the patient experienced disease progression or unacceptable toxicity while on the current regimen?

Yes  No Is the requested drug being used as adjuvant treatment of early 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.