



Phesgo™ (pertuzumab, trastuzumab, and hyaluronidase-zzxf)

Medication Precertification Request

Page 1 of 2

(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 #:	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 #:
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: <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): _____	Dispensing Provider/Pharmacy: Patient Selected choice <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: Phesgo (pertuzumab, trastuzumab, and hyaluronidase-zzxf) 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 Initiation Requests (clinical documentation required):

Breast cancer

What is the human epidermal growth factor receptor 2 (HER2) status? HER2 positive HER2 negative Unknown

Yes No Will the requested drug be used in combination with chemotherapy?

Please select the clinical setting in which the requested medication is being used:

Adjuvant therapy
↳ Yes No Is the disease node-positive or at high risk for recurrence?

Treatment of recurrent or metastatic disease

Neoadjuvant (pre-operative) treatment of breast cancer
↳ Yes No Is the disease locally advanced, inflammatory, or early stage (either greater than 2 cm in diameter or node positive)?

Other, Please explain: _____

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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 Is there evidence of unacceptable toxicity or disease progression on the current regimen?

Please select the clinical setting in which the requested medication is being used:

Neoadjuvant (pre-operative) treatment of breast cancer
 ↳ How many months of the requested medication has the patient received? _____
 Yes No Has the patient received the requested drug for 12 months (52 weeks or greater)?

Adjuvant therapy
 ↳ How many months of the requested medication has the patient received? _____
 Yes No Has the patient received the requested drug for 12 months (52 weeks or greater)?

Treatment of recurrent or metastatic disease

Other, Please explain: _____

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.