Polivy™ (polatuzumab vedotin-piig) 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:
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:		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):* ☐ **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: _____
☐ 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 Polivy (polatuzumab vedotin-piig) 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 for all requests):

Please indicate the requested regimen:
☐ The requested drug will be used as a single agent
☐ The requested drug will be used in combination with bendamustine only
☐ The requested drug will be used in combination with bendamustine and rituximab
☐ Other, please explain: _____

Please indicate how many cycles of chemotherapy containing the requested drug are planned: _____

Please indicate the place in therapy the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment

☐ **Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphomas (AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, AIDS-related plasmablastic lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma)**
☐ Yes ☐ No Will the requested medication be used as a bridging option until CAR T-cell product is available?
→ ☐ Yes ☐ No Is the patient a candidate for transplant?

☐ **Diffuse large B-cell lymphoma (DLBCL)**
☐ Yes ☐ No Will the requested medication be used as a bridging option until CAR T-cell product is available?
→ ☐ Yes ☐ No Is the patient a candidate for transplant?

☐ **Follicular lymphoma**

☐ **High-grade B-cell lymphomas (HGBLs) (also referred to as "double-hit" or "triple-hit" lymphomas)**
☐ Yes ☐ No Will the requested medication be used as a bridging option until CAR T-cell product is available?
→ ☐ Yes ☐ No Is the patient a candidate for transplant?

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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.

☐ **Histologic transformation of follicular lymphoma to diffuse large B-cell lymphoma without translocations of MYC and BCL2 and/or BCL6**

☐ **Histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma**

☐ Yes ☐ No Has the member received at least two prior chemoimmunotherapies?

☐ **Monomorphic post-transplant lymphoproliferative disorders (B-cell type)**

☐ Yes ☐ No Has the member received at least two prior chemoimmunotherapies?

For Continuation Requests (clinical documentation required for all requests):

Please indicate how many cycles of the requested drug the patient received in a lifetime: _____

☐ Yes ☐ No Is there evidence of unacceptable toxicity or disease progression while 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.