



bortezomib-VELCADE® Medication 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:		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 #: _____		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 Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: Patient Selected choice	
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office		<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy	
<input type="checkbox"/> Outpatient Infusion Center Phone: _____		<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other	
Center Name: _____		Name: _____	
<input type="checkbox"/> Home Infusion Center Phone: _____		Address: _____	
Agency Name: _____		Phone: _____ Fax: _____	
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____ PIN: _____	
Address: _____			

E. PRODUCT INFORMATION

Request is for: bortezomib-VELCADE 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 Multiple Myeloma Requests (clinical documentation required for all requests):

Please indicate the patient's Body Surface Area (BSA): _____ m²

Yes No Will the patient's dose exceed 1.6 mg/m²?

Yes No Does the patient require more than 7 doses per 30-day period?

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

Acute lymphoblastic leukemia

Adult T-cell leukemia/lymphoma

Kaposi's sarcoma

Antibody mediated rejection of solid organ

Follicular lymphoma

Hodgkin Lymphoma

Mantle cell lymphoma

Multicentric Castleman's disease

Multiple myeloma

POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome

Systemic light chain amyloidosis

Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma

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

Yes No Has the patient experienced unacceptable toxicity or disease progression while on the current regimen?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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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.