Bendamustine (Treanda®, Bendeka®, Belrapzo™) 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:
Please Use Medicare Request Form

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: ☐ **Treanda** ☐ **Bendeka** ☐ **Belrapzo**

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):

☐ **AIDS-related B-cell lymphoma**
- ☐ Yes ☐ No Will the requested drug be used as subsequent therapy?
- ☐ Yes ☐ No Is the patient a candidate for transplant?

☐ **Adult T-cell leukemia/lymphoma (ATLL)**
- ☐ Yes ☐ No Will the requested drug be used as a single agent?
- ☐ Yes ☐ No Will the requested drug be used as subsequent therapy?

☐ **Breast implant associated anaplastic large cell lymphoma (ALCL)**
- ☐ Yes ☐ No Will the requested drug be used as a single agent?
- ☐ Yes ☐ No Will the requested drug be used as subsequent therapy?

☐ **Chronic lymphocytic leukemia (CLL) without chromosome 17p deletion or without TP53 mutation**

☐ **Classical Hodgkin lymphoma**
- ☐ Yes ☐ No Will the requested drug be used as subsequent therapy or palliative therapy?

Please indicate the requested regimen:
- ☐ The requested drug will be used as a single agent
- ☐ The requested drug will be used in combination with brentuximab vedotin (Adcetris)
- ☐ The requested drug will be used in combination with gemcitabine and vinorelbine
- ☐ The requested drug will be used in combination with carboplatin and etoposide
- ☐ None of the above

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☐ **Cutaneous anaplastic large cell lymphoma (ALCL)**
- ☐ Yes ☐ No Will the requested drug be used as a single agent?
- ☐ Yes ☐ No Is the disease relapsed or refractory?

☐ **Diffuse large B-cell lymphoma**
- ☐ Yes ☐ No Will the requested drug be used as subsequent therapy?
- ☐ Yes ☐ No Is the patient a candidate for transplant?

Please indicate the requested regimen:
- ☐ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy)
- ☐ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy) and rituximab
- ☐ None of the above

☐ **Follicular lymphoma**

☐ **Hepatosplenic T-Cell Lymphoma**
- ☐ Yes ☐ No Will the requested drug be used as a single agent?
- ☐ Yes ☐ No Is the disease refractory?

☐ **High grade B-cell lymphoma**
- ☐ Yes ☐ No Will the requested drug be used as subsequent therapy?
- ☐ Yes ☐ No Is the patient a candidate for transplant?

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

Please indicate the requested regimen:
- ☐ The requested drug will be used as a single agent
- ☐ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy)
- ☐ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy) and rituximab
- ☐ None of the above

☐ Yes ☐ No Will the requested drug be used as subsequent therapy?

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

Please indicate how many lines of chemoimmunotherapy the patient has received: _____

Please indicate the requested regimen:
- ☐ The requested drug will be used as a single agent
- ☐ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy)
- ☐ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy) and rituximab
- ☐ The requested drug will be used in combination with rituximab
- ☐ None of the above

☐ **Mantle cell lymphoma (MCL)**

Please indicate the requested regimen:
- ☐ The requested drug will be used in combination with rituximab
- ☐ The requested drug will be used as a component of RBAC500 (rituximab, bendamustine, and cytarabine)
- ☐ None of the above

☐ **Marginal zone lymphoma (nodal, gastric MALT, non-gastric MALT, splenic)**

Please indicate the requested regimen:
- ☐ The requested drug will be used in combination with rituximab
- ☐ The requested drug will be used in combination with obinutuzumab (Gazyva)
- ☐ None of the above

☐ **Multiple myeloma**

Please indicate the requested regimen:
- ☐ The requested drug will be used as a single agent
- ☐ The requested drug will be used in combination with lenalidomide (Revlimid) and dexamethasone
- ☐ The requested drug will be used in combination with bortezomib (Velcade) and dexamethasone
- ☐ None of the above

☐ Yes ☐ No Is the disease relapsed or progressive?

☐ **Mycosis fungoides (MF)**

☐ **Nodular Lymphocyte Predominant Hodgkin lymphoma (NLPHL)**
- ☐ Yes ☐ No Will the requested drug be used as subsequent therapy?
- ☐ Yes ☐ No Will the requested drug be used in combination with rituximab?

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☐ **Post-transplant lymphoproliferative disorders**
- ☐ Yes ☐ No Will the requested drug be used as subsequent therapy?

Please indicate the requested regimen:
- ☐ The requested drug will be used as a single agent
- ☐ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy)
- ☐ The requested drug will be used in combination with polatuzumab vedotin-piiq (Polivy) and rituximab
- ☐ The requested drug will be used in combination with rituximab
- ☐ None of the above

☐ **Peripheral T-cell Lymphoma (PTCL) [including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, or follicular T-cell lymphoma]**
- ☐ Yes ☐ No Will the requested drug be used as a single agent?
- ☐ Yes ☐ No Will the requested drug be used as palliative or subsequent therapy?

☐ **Sezary syndrome (SS)**

☐ **Small lymphocytic lymphoma (SLL) without chromosome 17p deletion or without TP53 mutation**

☐ **Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma**

Please indicate the requested regimen:
- ☐ The requested drug will be used as a single agent
- ☐ The requested drug will be used in combination with rituximab
- ☐ None of the above

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

☐ 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.