



**Cosela™ (trilaciclib)**  
**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:	
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 #:	UPIN:
Provider Email:		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: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	<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: _____ <b>TIN:</b> _____ <b>PIN:</b> _____
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**E. PRODUCT INFORMATION**

**Request is for Cosela (trilaciclib) 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 for all requests):**  
**Extensive-stage small cell lung cancer**  
 Yes  No Is the requested medication being used to decrease the incidence of chemotherapy-induced myelosuppression?  
Please indicate which of the following chemotherapeutic regimens the patient is receiving:  Platinum/etoposide-containing regimen  
 Topotecan-containing regimen  
 Other  
 Yes  No Will the requested drug be given within 4 hours prior to the start of chemotherapy on each day chemotherapy is administered?  
 Yes  No Will the requested medication be used with a granulocyte colony-stimulating factor (G-CSF) as primary prophylaxis during cycle 1?  
 Yes  No Will the requested medication be used with erythropoiesis-stimulating agents (ESAs) as primary prophylaxis during cycle 1?

**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.