Enhertu® (fam-trastuzumab deruxtecan-nxki) 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:		
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 #: _____
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 Enhertu (fam-trastuzumab deruxtecan-nxki) 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):

☐ **Breast cancer**
Please indicate the clinical setting in which the requested drug will be used:
☐ Recurrent disease ☐ Metastatic disease ☐ Unresectable disease ☐ Other
Please indicate the patient's human epidermal growth factor receptor 2 (HER2) status: ☐ HER2 positive ☐ HER2 negative ☐ Unknown
☐ Yes ☐ No Has the patient received treatment with two or more anti-HER2 based regimens?
☐ Yes ☐ No Will requested drug be used as a single agent?

☐ **Colorectal cancer**
☐ Yes ☐ No ☐ Unknown Does the patient have HER2- amplified disease?
☐ Yes ☐ No ☐ Unknown Does the patient have RAS and BRAF wild-type disease?
☐ Yes ☐ No Will requested drug be used as a single agent?
☐ Yes ☐ No Is the patient appropriate for intensive therapy?
☐ Yes ☐ No Will the requested drug be used as subsequent therapy for progression of advanced or metastatic disease?

☐ **Gastric or gastroesophageal junction adenocarcinoma**
Please indicate the patient's human epidermal growth factor receptor 2 (HER2) status: ☐ HER2 positive ☐ HER2 negative ☐ Unknown
Please indicate the clinical setting in which the requested drug will be used: ☐ Locally advanced disease ☐ Metastatic disease ☐ Other
☐ Yes ☐ No Has the patient received a prior trastuzumab-based regimen?
☐ Yes ☐ No Will requested drug be used as a single agent?

Continued on next page

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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.

☐ **Non-small cell lung cancer**

☐ Yes ☐ No ☐ Unknown Is the patient's disease positive for HER2 mutations?

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

☐ Yes ☐ No Is there evidence of unacceptable toxicity or disease progression while receiving the requested drug 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.