



Herceptin® (trastuzumab) 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

Place of Administration: <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: _____ Address: _____ <input type="checkbox"/> Administration code(s) (CPT): _____	Dispensing Provider/Pharmacy: <i>Patient Selected choice</i> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for: Herceptin (trastuzumab) 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):
What is the human epidermal growth factor receptor 2 (HER2) status? HER2 positive HER2 negative Unknown
ACTION REQUIRED: Please attach documentation of human epidermal growth factor receptor 2 (HER2) status.

Breast cancer
 Yes No Will the requested drug be used for the intra-cerebrospinal fluid (CSF) treatment for leptomeningeal metastases from breast cancer?
 In what clinical setting will the requested drug be used?
 Adjuvant therapy
 Preoperative (neoadjuvant) therapy
 Treatment of recurrent or metastatic disease
 Other (please specify) _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Colorectal Cancer

- Yes No Does the patient have HER2- amplified and RAS wild-type disease?
- Yes No Will the requested drug be used in combination with pertuzumab or lapatinib?
- Yes No Is the patient appropriate for intensive therapy?
- Yes No Will trastuzumab be used as subsequent therapy for disease progression?
- Does the patient have advanced or metastatic disease? Advanced disease Metastatic Disease

Esophageal cancer Gastric cancer Gastroesophageal Junction cancer

- Yes No Will the requested medication be used in combination with chemotherapy?
- Please provide the name of the systemic chemotherapy: _____

Salivary gland tumors

- Yes No Does the patient have recurrent disease?
- Yes No Does the patient have distant metastases?

Uterine Serous Sarcoma

- Yes No Will the requested drug be used in combination with carboplatin and paclitaxel?
- Does the patient have advanced or recurrent disease? Advanced disease Recurrent Disease Other: Please explain: _____

For Continuation Requests (clinical documentation required):

- Yes No Has the patient experienced disease progression or unacceptable toxicity while on HER2 therapy?
- Please indicate: Disease progression Unacceptable toxicity
- Yes No Is the requested drug being used as adjuvant/neoadjuvant treatment of breast cancer?
- How many months of the requested medication has the patient received?
- Please provide initial start date: ____ / ____ / ____

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.