



Ogivri™ (trastuzumab-dkst) 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: Patient Selected choice <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: Ogivri (trastuzumab-dkst) **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

Yes No Has the patient had a contraindication, intolerance or ineffective response to Herceptin?
Please identify: Contraindication Intolerance Ineffective response

Yes No Has the patient had a contraindication, intolerance or ineffective response to Kanjinti?
Please identify: Contraindication Intolerance Ineffective response

Yes No Has the patient had a contraindication, intolerance or ineffective response to Trazimera?
Please identify: Contraindication Intolerance Ineffective response

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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.

Breast cancer

Please indicate the clinical setting in which the requested drug will be used:

Adjuvant therapy

→ Yes No Has the patient received the requested drug for 12 months (52 weeks) or greater as adjuvant therapy?

Preoperative (neoadjuvant) therapy

→ Yes No Will the requested drug be used as part of a complete treatment regimen?

Yes No Has the patient received the requested drug for 12 months (52 weeks) or greater as adjuvant therapy?

Treatment of recurrent, advanced unresectable, or metastatic disease (including brain metastases)

Intra-cerebrospinal fluid (CSF) treatment for leptomeningeal metastases from breast cancer

Other (please specify): _____

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 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?

Yes No Does the patient have advanced or metastatic disease?

→ Please explain: advanced disease metastatic disease

Esophageal cancer **Gastric cancer** **Gastroesophageal Junction cancer**

Yes No Will the requested medication be used in combination with chemotherapy?

Salivary gland tumors

Uterine serous carcinoma

Yes No Will the requested drug be used in combination with carboplatin and paclitaxel?

Yes No Does the patient have advanced or recurrent disease?

→ Please explain: advanced disease recurrent disease

For Continuation Requests (clinical documentation required):

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

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? _____

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.