



# Xofigo® (radium RA 223 dichloride) Injectable 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:		DOB:	
Address:			City:		State: ZIP:
Home Phone:		Work Phone:		Cell Phone:	
E-mail:		Allergies:			
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 E-mail:			Office Contact Name:		Phone:
Specialty (Check one): Oncologist: <input type="checkbox"/> Radiation 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: _____ TIN: _____ PIN: _____
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### E. PRODUCT INFORMATION

Request is for  Xofigo 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):**

Yes  No Has the patient been diagnosed with prostate cancer?  
 Yes  No Is the patient symptomatic?  
 Yes  No Does the patient have clinical evidence of metastasis from prostate cancer?  
 Yes  No Has the cancer spread to bones but not to other organs?  
 Yes  No Is the prostate cancer castration-resistant?

**For Continuation Requests (Clinical documentation required for all requests):**

Yes  No Has the patient experienced unacceptable toxicity or disease progression while on Xofigo?  
 Please indicate how many injections of Xofigo the patient has 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.