Adcetris® (brentuximab vedotin) Injectable Medication Precertification Request

Aetna Precertification Notification
Phone: 1-866-752-7021 **(TTY:** 711**)**
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

(All fields must be completed and legible for precertification review.)

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:	E-mail:	

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 E-mail:	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: _____
Phone: _____ Fax: _____
Address: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Adcetris (brentuximab vedotin): 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):

☐ Yes ☐ No Has testing or analysis been completed which confirms CD30 expression on the surface of the cell?
→ **ACTION REQUIRED: If 'Yes', please attach supporting laboratory report or medical record indicating CD30 positive disease.**

For Initiation Requests (clinical documentation required):

Adult T-cell leukemia/lymphoma
Please indicate the requested regimen:
☐ The requested drug will be used as a single agent
→ Please indicate the place in therapy the requested drug will be used: ☐ initial therapy ☐ subsequent therapy
☐ The requested drug will be used in combination with cyclophosphamide, doxorubicin, and prednisone
☐ Other: please explain: _____

HIV-related B-cell lymphoma (CD30+ HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma), Diffuse large B-cell lymphoma or High Grade B-cell lymphoma
Please select the indication being treated:
☐ HIV-related B-cell lymphoma (CD30+ HIV-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8) positive diffuse large B-cell lymphoma) ☐ Diffuse large B-cell lymphoma ☐ High-grade B-cell lymphomas
Please indicate the place in therapy the requested drug will be used: ☐ initial therapy ☐ subsequent therapy
☐ Yes ☐ No Is the patient a candidate for transplant?

Continued on next page.

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G. CLINICAL INFORMATION ***(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

Breast implant associated anaplastic large cell lymphoma, Cutaneous anaplastic large cell lymphoma, Systemic anaplastic large cell lymphoma (ALCL)

Please select the indication being treated: ☐ Breast implant associated anaplastic large cell lymphoma ☐ Cutaneous anaplastic large cell lymphoma ☐ Systemic anaplastic large cell lymphoma (ALCL)

What is the requested regimen?

☐ The requested drug will be used as a single agent
☐ The requested drug will be used in combination with cyclophosphamide, doxorubicin, and prednisone
☐ Other: please explain: _____

Classical Hodgkin lymphoma

What is the requested regimen?

☐ The requested drug will be used as a single agent
☐ The requested drug will be used in combination with doxorubicin, vinblastine, dacarbazine
☐ The requested drug will be used in combination with bendamustine
→ Please indicate the place in therapy the requested drug will be used: ☐ initial therapy ☐ subsequent therapy
☐ The requested drug will be used in combination with dacarbazine
☐ The requested drug will be used in combination with nivolumab
→ Please indicate the place in therapy the requested drug will be used: ☐ initial therapy ☐ subsequent therapy
☐ The requested drug will be used in combination with gemcitabine
→ Please indicate the place in therapy the requested drug will be used: ☐ initial therapy ☐ subsequent therapy
☐ The requested drug will be used in combination with ifosfamide, carboplatin and etoposide
→ Please indicate the place in therapy the requested drug will be used: ☐ initial therapy ☐ subsequent therapy
☐ The requested drug will be used in combination with cyclophosphamide, prednisone and dacarbazine
→ Please indicate the place in therapy the requested drug will be used: ☐ initial therapy ☐ subsequent
☐ The requested drug will be used in combination with etoposide, prednisone and doxorubicin
☐ The requested drug will be used in combination with doxorubicin, vincristine, etoposide, prednisone and cyclophosphamide
☐ Other: please explain: _____

Extranodal NK/T-cell lymphoma

☐ Yes ☐ No Will the requested drug be used as a single agent?
☐ Yes ☐ No Is the disease relapsed or refractory?
☐ Yes ☐ No Has the patient had an inadequate response to asparaginase-based therapy (e.g., pegaspargase)?
→ ☐ Yes ☐ No Does the patient have a contraindication to asparaginase-based therapy (e.g., pegaspargase)?

Hepatosplenic T-cell lymphoma

☐ Yes ☐ No Will the requested drug be used as a single agent?
→ ☐ Yes ☐ No Will the requested drug be used in combination with cyclophosphamide, doxorubicin, and prednisone?
→ ☐ Other treatment regimen: please explain: _____

How many previous lines of primary treatment regimens has the patient received? ☐ Zero ☐ One ☐ Two or more

Lymphomatoid papulosis (LyP)

☐ Yes ☐ No Will requested drug will be used be used as a single-agent?
☐ Yes ☐ No Is the patient's disease relapsed or refractory?

Mycosis fungoides/Sezary syndrome

Please select which of the following the patient is being treated for: ☐ Mycosis fungoides ☐ Sezary syndrome

Monomorphic post-transplant lymphoproliferative disorders (B-cell type)

Please indicate the place in therapy the requested drug will be used: ☐ initial therapy ☐ subsequent therapy
☐ Yes ☐ No Is the patient a candidate for transplant?

Monomorphic post-transplant lymphoproliferative disorders (T-cell type)

☐ Yes ☐ No Will the requested drug be used in combination with cyclophosphamide, doxorubicin, and prednisone?

Pediatric primary mediastinal large B-cell lymphoma

☐ Yes ☐ No Is the disease relapsed or refractory?
☐ Yes ☐ No Will the requested drug be used in combination with nivolumab or pembrolizumab?

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Peripheral T-cell lymphoma (PTCL) [including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, or follicular T-cell lymphoma]

Please select the indication being treated:

☐ Peripheral T-cell lymphoma (PTCL) [including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, or follicular T-cell lymphoma] ☐ Angioimmunoblastic T-cell lymphoma

Please indicate the requested regimen:

☐ The requested drug will be used as a single agent
→ Please indicate the place in therapy the requested drug will be used: ☐ subsequent therapy ☐ palliative therapy ☐ other

☐ The requested drug will be used in combination with cyclophosphamide, doxorubicin, and prednisone

☐ Other: please explain: _____

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Is there evidence of unacceptable toxicity or disease progression while 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.