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 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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):

☐ Yes ☐ No Does the patient have a solid tumor?
→ **If "No", please select the diagnosis from below**
→ Please indicate the clinical setting in which the requested drug will be used:
☐ Unresectable disease ☐ Metastatic disease ☐ Other, please identify and select the diagnosis from below: _____
☐ Yes ☐ No ☐ Unknown Is the tumor is HER2-positive (IHC 3+)?
→ **If "No" or "Unknown", please select the diagnosis from below**
☐ Yes ☐ No Has the patient received prior systemic treatment?
→ **If "No", please select the diagnosis from below**
☐ Yes ☐ No Are there other satisfactory alternative treatment options available for the patient?
→ **If "Yes", please select the diagnosis from below**

☐ **Biliary tract cancer (intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma, or gallbladder cancer)**
Please indicate the clinical setting in which the requested drug will be used: ☐ Unresectable disease ☐ Resected gross residual (R2) disease ☐ Metastatic disease ☐ Other
☐ Yes ☐ No ☐ Unknown Does the patient have HER2-positive (IHC 3+) disease?
Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment
☐ 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.

☐ **Breast cancer**
- ☐ Yes ☐ No Will requested drug be used as a single agent?
- Please indicate which of the following applies to the patient's disease:
  - ☐ Human epidermal growth factor receptor 2 (HER2) positive breast cancer
    - → Please indicate the clinical setting in which the requested drug will be used:
      - ☐ Recurrent disease ☐ Metastatic disease ☐ Unresectable disease
      - ☐ The disease had no response to preoperative systemic therapy ☐ Other
  - ☐ HER2-low (IHC 1+ or IHC 2+/ISH-) breast cancer
    - → Please indicate the clinical setting in which the requested drug will be used: ☐ The disease had no response to preoperative systemic therapy
      - ☐ Recurrent disease ☐ Metastatic disease ☐ Unresectable disease ☐ Other
      - ☐ Yes ☐ No Has the patient tried at least one prior chemotherapy?
  - ☐ Unknown HER2 status

☐ **Cervical Cancer**
- ☐ Yes ☐ No ☐ Unknown Does the patient have HER2-positive (IHC 3+ or 2+) cervical cancer?
- Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Metastatic disease ☐ Other
- Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment
- ☐ Yes ☐ No Will requested drug be used as a single agent?

☐ **Colorectal cancer (including appendiceal and adenocarcinoma)**
- ☐ Yes ☐ No ☐ Unknown Does the patient have HER2- amplified disease?
- ☐ Yes ☐ No Will requested drug be used as a single agent?
- ☐ Yes ☐ No Will the requested drug be used as subsequent therapy for progression of advanced or metastatic disease?

☐ **Endometrial carcinoma**
- ☐ Yes ☐ No ☐ Unknown Does the patient have HER2-positive (IHC 3+ or 2+) endometrial carcinoma?
- Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Other
- Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment
- ☐ Yes ☐ No Will requested drug be used as a single agent?

☐ **Epithelial ovarian, fallopian tube, or primary peritoneal cancer**
- Please indicate the clinical setting in which the requested drug will be used:
- ☐ Platinum-resistant persistent disease ☐ Platinum-resistant recurrent disease ☐ Other
- ☐ Yes ☐ No ☐ Unknown Does the patient have HER2-positive (IHC 3+ or 2+) disease?
- ☐ Yes ☐ No Will requested drug be used as a single agent?

☐ **Esophageal, 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 ☐ Recurrent disease ☐ Metastatic disease ☐ The patient is not a surgical candidate ☐ Other
- Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment
- ☐ Yes ☐ No Will requested drug be used as a single agent?

☐ **Non-small cell lung cancer**
- ☐ Yes ☐ No ☐ Unknown Is the patient's disease positive for HER2 (ERBB2) mutations?
- ☐ Yes ☐ No Will requested drug be used as a single agent?
- Please indicate the clinical setting in which the requested drug will be used: ☐ Advanced disease ☐ Recurrent disease ☐ Metastatic disease ☐ Unresectable disease ☐ Other
- Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment

☐ **Salivary gland tumor**
- ☐ Yes ☐ No ☐ Unknown Does the patient have HER2- positive salivary gland tumor?
- Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Unresectable disease ☐ Metastatic disease ☐ Other
- ☐ Yes ☐ No Will requested drug be used as a single agent?

☐ **Vaginal cancer**
- Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Metastatic disease ☐ Other
- Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment
- ☐ Yes ☐ No ☐ Unknown Does the patient have HER2-positive (IHC 3+ or 2+) disease?
- ☐ Yes ☐ No Will requested drug be used as a single agent?

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

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