Herceptin® and Trastuzumab Biosimilars 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: _____
Address: _____
☐ Administration code(s) (CPT): _____

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: ☐ **Herceptin (trastuzumab)** ☐ **Herzuma (trastuzumab-pkrb)** ☐ **Kanjinti (trastuzumab-anns)** ☐ **Ogivri (trastuzumab-dkst),** ☐ **Ontruzant (trastuzmab-dttb)** ☐ **Trazimera (trastuzumab-qyyp)**

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.

☐ Yes ☐ No Is this request for Herceptin (trastuzumab), Kanjinti (trastuzumab-anns), Trazimera (trastuzumab-qyyp), or Ontruzant (trastuzmab-dttb)?
→ ☐ Yes ☐ No Has the patient tried and failed treatment with Herzuma (trastuzumab-pkrb) and Ogivri (trastuzumab-dkst) due to a documented intolerable adverse event (e.g., rash, nausea, vomiting)?
☐ Yes ☐ No Was the adverse event unexpected and not attributed to the active ingredient as described in the prescribing information?

For Initiation Requests (clinical documentation required):
What is the human epidermal growth factor receptor 2 (HER2) status? ☐ HER2 positive ☐ HER2 negative ☐ Unknown
☐ **Breast cancer**
Please indicate the clinical setting in which the requested drug will be used:
☐ Adjuvant therapy
→ How many months has the patient received therapy with the requested drug? _____
☐ Preoperative (neoadjuvant) therapy
→ ☐ Yes ☐ No Will the requested drug be used as part of a complete treatment regimen?
How many months has the patient received therapy with the requested drug? _____

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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.

☐ Treatment of disease that has not responded to preoperative systemic therapy, 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, including appendiceal adenocarcinoma and anal adenocarcinoma**
☐ Yes ☐ No ☐ Unknown Does the patient have HER2- positive/amplified disease?
☐ Yes ☐ No ☐ Unknown Is the disease negative (wild-type) for RAS (KRAS and NRAS) and BRAF mutations ?
☐ Yes ☐ No Will the requested drug be used in combination with tucatinib (Tukysa), pertuzumab (Perjeta), or lapatinib (Tykerb)?
What is clinical setting in which the requested drug will be used? ☐ Unresectable disease ☐ Advanced disease ☐ Metastatic disease ☐ Other
☐ Yes ☐ No Has the patient received prior therapy for the disease?
→ ☐ Yes ☐ No Is the patient appropriate for intensive therapy?

☐ **Esophageal cancer** ☐ **Gastric cancer** ☐ **Gastroesophageal Junction cancer**
☐ Yes ☐ No Will the requested drug be used for treatment or palliative therapy of esophageal, gastric, or gastroesophageal junction cancer?
☐ Yes ☐ No Will the requested medication be used in combination with chemotherapy?

☐ **Hepatobiliary cancers, including intrahepatic and extrahepatic cholangiocarcinoma and gallbladder cancer**
What is clinical setting in which the requested drug will be used? ☐ Unresectable 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 the requested drug be used in combination with pertuzumab (Perjeta)?

☐ **Salivary gland tumors**

☐ **Uterine serous carcinoma**
☐ Yes ☐ No Will the requested drug be used in combination with carboplatin and paclitaxel?
What is clinical setting in which the requested drug will be used? ☐ Advanced disease ☐ Recurrent disease ☐ Metastatic disease ☐ Other

For Continuation Requests (clinical documentation required):
☐ Yes ☐ No Is there evidence of unacceptable toxicity or disease progression 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 drug 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.