LUTATHERA® (lutetium Lu 177 dotatate) 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:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms			Allergies:	

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: ☐ **LUTATHERA (lutetium Lu 177 dotatate) 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 for all requests):

☐ Yes ☐ No Will the patient receive more than 4 doses total of the requested drug?

☐ **Carcinoid syndrome, poorly controlled**
- ☐ Yes ☐ No/unknown Does the patient have somatostatin receptor-positive neuroendocrine tumors of the gastrointestinal tract, lung or thymus?
- ☐ Yes ☐ No Has the patient experienced progression on octreotide long-acting release (LAR) [Sandostatin LAR] or lanreotide (Somatuline Depot)?

Please indicate the regimen:
- ☐ In combination with octreotide LAR (Sandostatin LAR) *OR* ☐ In combination with lanreotide (Somatuline Depot)
  - → ☐ Yes ☐ No Does the patient have persistent symptoms (i.e., flushing, diarrhea)?
- ☐ In combination with telotristat (Xermelo)
  - → ☐ Yes ☐ No Does the patient have persistent diarrhea?

Please indicate how the requested medication will be used:
☐ In combination with octreotide LAR (Sandostatin LAR) ☐ In combination with lanreotide (Somatuline Depot) ☐ Other

☐ Other regimen

☐ **Neuroendocrine tumors of the gastrointestinal (GI) tract (carcinoid tumors)**

Please indicate the clinical setting in which the requested medication will be used:
☐ Recurrent disease ☐ Locoregional advanced disease ☐ Distant metastatic disease ☐ Other

☐ Yes ☐ No/unknown Does the patient have either of the following: a) clinically significant tumor burden or b) disease that has progressed on octreotide LAR (Sandostatin LAR) or lanreotide (Somatuline Depot)?
→ Please explain: ☐ clinically significant tumor burden ☐ disease progression on octreotide LAR or lanreotide

☐ Yes ☐ No/unknown Are the patient's tumors somatostatin receptor-positive?

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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.

☐ **Neuroendocrine tumors of the lung and thymus (carcinoid tumors)**

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

☐ Recurrent disease
☐ Locoregional unresectable disease
☐ Distant metastatic disease
→ ☐ Yes ☐ No/unknown Does the patient have any of the following: a) clinically significant tumor burden and low grade (typical carcinoid) histology, b) evidence of progression, c) intermediate grade (atypical carcinoid) histology, and/or d) symptomatic disease?
→ Please explain: ☐ clinically significant tumor burden and low grade (typical carcinoid) histology
☐ evidence of disease progression ☐ intermediate grade (atypical carcinoid) histology ☐ symptomatic disease
☐ Other clinical setting

☐ Yes ☐ No/unknown Are the patient's tumors somatostatin receptor-positive?
☐ Yes ☐ No Has the patient experienced disease progression on octreotide LAR (Sandostatin LAR) or lanreotide (Somatuline Depot)?

☐ **Neuroendocrine tumors of the pancreas**

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

☐ Symptomatic disease ☐ Clinically significant tumor burden ☐ Progressive recurrent locoregional advanced disease ☐ Distant metastases
☐ Progressive recurrent locoregional advanced disease and distant metastases ☐ Other

☐ Yes ☐ No/unknown Are the patient's tumors somatostatin receptor-positive?
☐ Yes ☐ No Has the patient experienced disease progression on octreotide LAR (Sandostatin LAR) or lanreotide (Somatuline Depot)?

☐ **Pheochromocytoma/paraganglioma**

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

☐ Locally unresectable disease ☐ Distant metastases ☐ Other

☐ Yes ☐ No/unknown Does the patient have somatostatin receptor-positive pheochromocytoma/paraganglioma?

☐ **Well-differentiated grade 3 neuroendocrine tumors (NETs) with favorable biology**

☐ Yes ☐ No/unknown Does the patient's tumor have favorable biology (e.g., relatively low Ki-67 [less than 55%], slow growing, positive somatostatin receptor [SSTR]-based PET imaging)?

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

☐ Unresectable locally advanced disease ☐ Metastatic disease ☐ Other

☐ Yes ☐ No/unknown Does the patient have either of the following: a) clinically significant tumor burden or b) evidence of disease progression?
→ Please explain: ☐ clinically significant tumor burden ☐ evidence of disease progression

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.