Phesgo® (pertuzumab, trastuzumab, and hyaluronidase-zzxf) 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: ________
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: Phesgo (pertuzumab, trastuzumab, and hyaluronidase-zzxf) **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):

☐ **Breast cancer**

What is the human epidermal growth factor receptor 2 (HER2) status? ☐ HER2 positive ☐ HER2 negative ☐ Unknown

Please select the clinical setting in which the requested medication is being used:

☐ Adjuvant therapy
→ ☐ Yes ☐ No Is the disease node-positive or at high risk for recurrence?
How many months has the patient received therapy with the requested medication? ____
☐ Yes ☐ No Will the requested drug be used in combination with chemotherapy?

☐ Neoadjuvant (pre-operative) treatment of breast cancer
→ ☐ Yes ☐ No Is the disease locally advanced, inflammatory, or early stage (either greater than 2 cm in diameter or node positive)?
How many months has the patient received therapy with the requested medication? ____
☐ Yes ☐ No Will the requested drug be used in combination with chemotherapy?

☐ Treatment of recurrent disease, metastatic disease or the disease had no response to preoperative systemic therapy
→ What is the clinical setting in which the requested drug will be used? ☐ Metastatic disease ☐ Recurrent disease ☐ The disease had no response to preoperative systemic therapy

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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.

☐ Other, Please explain: ____________________

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Is there evidence of unacceptable toxicity or disease progression on the current regimen?

Please select the clinical setting in which the requested medication is being used:

☐ Neoadjuvant (pre-operative) treatment of breast cancer
→ How many months of the requested medication has the patient received? _____
☐ Yes ☐ No Has the patient received the requested drug for 12 months (52 weeks or greater)?

☐ Adjuvant therapy
→ How many months of the requested medication has the patient received? _____
☐ Yes ☐ No Has the patient received the requested drug for 12 months (52 weeks or greater)?

☐ Treatment of recurrent disease, metastatic disease or the disease had no response to preoperative systemic therapy

☐ Other, Please explain: ____________________

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.