# Qalsody® (tofersen) 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):* ☐ **Neurologist** ☐ **Neuromuscular specialist** ☐ **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: Qalsody (tofersen) 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 the patient been diagnosed with amyotrophic lateral sclerosis (ALS)?
☐ Yes ☐ No Will the requested medication be prescribed by or in consultation with a neurologist, neuromuscular specialist, or physician specializing in the treatment of amyotrophic lateral sclerosis (ALS)?
☐ Yes ☐ No Will the administration of the requested drug be provided at an Aetna designated gene therapy treatment center?
→ Please indicate the designated gene therapy treatment center: _____

**Initial Requests (clinical documentation required):**

☐ Yes ☐ No Does the patient have a weakness attributable to ALS (e.g., medical history and/or diagnostic testing including nerve conduction studies, imaging, and laboratory values to support the diagnosis)?
☐ Yes ☐ No Does the patient have an SOD1 mutation confirmed via genetic testing?
☐ Yes ☐ No Does the patient have a forced vital capacity (FVC) or slow vital capacity (SVC) greater than or equal to 45% of the predicted value for gender, height, and age?
☐ Yes ☐ No Does the patient have a tracheostomy?

**Continuation Requests (clinical documentation required):**

☐ Yes ☐ No Does the patient require invasive ventilation or tracheostomy?
☐ Yes ☐ No Has the patient demonstrated a clinical benefit from therapy with the requested medication?

***Continued on next page***

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

## 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.