RYPLAZIM (plasminogen, human-tvmh) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

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):* ☐ **Hematologist** ☐ **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: ☐ **RYPLAZIM (plasminogen, human-tvmh) 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 Does the patient have a diagnosis of plasminogen deficiency type 1 (hypoplasminogenemia)

For Initiation Requests (clinical documentation required):

Please indicate the patient's plasminogen activity level at baseline: _____ %

☐ Yes ☐ No Does the patient have a documented history of lesions and symptoms consistent with a diagnosis of plasminogen deficiency type 1 (e.g., ligneous conjunctivitis, ligneous gingivitis or gingival overgrowth, vision abnormalities, respiratory distress and/or obstruction, abnormal wound healing)?

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Has the patient experienced benefit from therapy as evidenced by disease stability or disease improvement (e.g., improvement in lesion number and/or size, absence of new lesion development, improvement in respiratory function, increased quality of life)?

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.