Trodelvy® (sacituzumab govitecan-hziy) 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: Trodelvy (sacituzumab govitecan-hziy) 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 for all requests):

☐ **Breast cancer**
☐ Yes ☐ No Will the requested drug be used as a single agent?
Which of the following applies to the patient's disease? ☐ Triple negative breast cancer ☐ The cancer cells are hormone receptor positive ☐ Other

Triple negative breast cancer:
☐ Yes ☐ No ☐ Unknown Does the patient have a diagnosis of triple-negative breast cancer confirmed by the breast cancer cells testing negative for ALL of the following receptors: A) human epidermal growth factor receptor 2 (HER2), B) estrogen, and C) progesterone?
☐ Yes ☐ No Has the patient received at least two prior therapies, with at least one line for metastatic disease?
Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Metastatic disease
☐ Unresectable disease ☐ The patient had no response to preoperative systemic therapy ☐ Other

The cancer cells are hormone receptor positive:
☐ Yes ☐ No ☐ Unknown Is the human epidermal growth factor receptor 2 (HER2)-negative?
☐ Yes ☐ No Has the patient received prior treatment with endocrine therapy (e.g., anastrozole [Arimidex], letrozole [Femara], fulvestrant [Faslodex])?
☐ Yes ☐ No Has the patient received prior treatment with a CDK4/6 inhibitor (e.g., abemaciclib [Verzenio], palbociclib [Ibrance], ribociclib [Kisqali])?
☐ Yes ☐ No Has the patient received prior treatment with at least two lines of chemotherapy (including a taxane) at least one of which was in the metastatic setting?
☐ Yes ☐ No Is the patient a candidate for fam-trastuzumab deruxtecan-nxki (Enhertu)?
Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent unresectable disease ☐ Metastatic disease
☐ The patient had no response to preoperative systemic therapy ☐ Other

☐ **Urothelial Carcinoma – Bladder cancer**
☐ Yes ☐ No Will the requested drug be used as a single agent?
What is the place in therapy in which the requested drug will be used? ☐ First-line treatment ☐ Subsequent treatment
Please indicate the clinical setting in which the requested drug will be used: ☐ Locally advanced disease ☐ Recurrent disease ☐ Persistent disease
☐ Metastatic disease ☐ Other

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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.

☐ Yes ☐ No Has the patient received a platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?

☐ Yes ☐ No Has the patient received either a programmed death receptor-1 (PD-1) or a programmed death-ligand 1 (PD-L1) inhibitor?

→ Please explain:

☐ A programmed death receptor-1 (PD-1) inhibitor (e.g., Keytruda, Opdivo)

☐ A programmed death-ligand 1 (PD-L1) inhibitor (e.g., Bavencio, Tecentriq)

☐ **Urothelial Carcinoma – Primary Carcinoma of the Urethra**

☐ Yes ☐ No Will the requested drug be used as a single agent?

What is the place in therapy in which the requested drug will be used? ☐ First-line treatment ☐ Subsequent treatment

Please indicate the clinical setting the requested drug will be used: ☐ Locally advanced disease ☐ Recurrent disease ☐ Metastatic disease ☐ Other

☐ Yes ☐ No Has the patient received a platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?

☐ Yes ☐ No Has the patient received either a programmed death receptor-1 (PD-1) or a programmed death-ligand 1 (PD-L1) inhibitor?

→ Please explain:

☐ A programmed death receptor-1 (PD-1) inhibitor (e.g., Keytruda, Opdivo)

☐ A programmed death-ligand 1 (PD-L1) inhibitor (e.g., Bavencio, Tecentriq)

☐ **Upper Genitourinary Tract Tumors or Urothelial Carcinoma (UC) of the Prostate**

☐ Yes ☐ No Will the requested drug be used as a single agent?

What is the place in therapy in which the requested drug will be used? ☐ First-line treatment ☐ Subsequent treatment

Please indicate the clinical setting the requested drug will be used: ☐ Locally advanced ☐ Metastatic disease ☐ Other

☐ Yes ☐ No Has the patient received a platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?

☐ Yes ☐ No Has the patient received either a programmed death receptor-1 (PD-1) or a programmed death-ligand 1 (PD-L1) inhibitor?

→ Please explain:

☐ A programmed death receptor-1 (PD-1) inhibitor (e.g., Keytruda, Opdivo)

☐ A programmed death-ligand 1 (PD-L1) inhibitor (e.g., Bavencio, Tecentriq)

For Continuation Requests (clinical documentation required for all requests):

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

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.