bortezomib-VELCADE® 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: ☐ **bortezomib** ☐ **VELCADE** **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):

Please indicate the patient's Body Surface Area (BSA): ____m^2
☐ Yes ☐ No Will the patient's dose exceed 1.6 mg/m^2?
☐ Yes ☐ No Does the patient require more than 7 doses per 30-day period?

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

☐ **Acute lymphoblastic leukemia**
☐ **Adult T-cell leukemia/lymphoma**
☐ Yes ☐ No Will the requested medication be used as a single agent?
Please indicate the place in therapy in which the requested medication will be used: ☐ First-line therapy ☐ Subsequent therapy
☐ **Antibody mediated rejection of solid organ**
☐ **Pediatric Classic Hodgkin Lymphoma**
Please indicate the clinical setting in which the requested medication will be used: ☐ Relapsed disease ☐ Refractory disease ☐ Other
☐ **Follicular lymphoma**
Please indicate the clinical setting in which the requested medication will be used: ☐ Relapsed disease ☐ Refractory disease ☐ Other
☐ **Kaposi sarcoma**
Please indicate the place in therapy in which the requested medication will be used: ☐ First-line therapy ☐ Subsequent therapy
☐ **Mantle cell lymphoma**
☐ **Multicentric Castleman disease**
Please indicate the place in therapy in which the requested medication will be used: ☐ First-line therapy ☐ Subsequent therapy
☐ **Multiple myeloma**

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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.

☐ **POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome**
☐ Yes ☐ No Will the requested medication be used in combination with dexamethasone?

☐ **Systemic light chain amyloidosis**

☐ **Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma**

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

☐ Yes ☐ No Has the patient experienced 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.