MEDICARE FORM

Abraxane® (paclitaxel protein-bound particles) Injectable Medication Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Abraxane and generic paclitaxel (protein bound) are non-preferred. The preferred products are docetaxel or paclitaxel. Docetaxel and paclitaxel do not require precertification.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to: **Phone:** 1-866-503-0857 **(TTY:** 711**)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-364-0974 **Fax:** 1-855-734-9389 **Availity:** https://www.aetnabetterhealth.com/ohio/providers/portal
For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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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:	E-mail:
Current Weight: _____ lbs or _____ kgs 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: _____

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 E-mail:		Office Contact Name:		Phone:	

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: _____
NPI: _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: Abraxane (paclitaxel protein-bound): Dose: _____ **Frequency:** _____ **HCPCS Code:** _____

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.

Note: Abraxane and generic paclitaxel (protein bound) are non-preferred. The preferred products are docetaxel or paclitaxel. Docetaxel and paclitaxel do not require precertification.

☐ Yes ☐ No Has the patient had prior therapy with Abraxane (paclitaxel protein-bound) within the last 365 days?

☐ No Has the patient had a trial and failure of any of the following? (if yes, select all that apply below)
- ☐ docetaxel ☐ conventional paclitaxel
  - → When was the member's trial and failure of the preferred drug? _____
  - → Please describe the nature of the failure of the preferred drug _____

☐ No Has the patient had an adverse reaction to any of the following? (if yes, select all that apply below)
- ☐ docetaxel ☐ conventional paclitaxel
  - → When was the member's adverse reaction to the preferred drug? _____
  - → Please describe the nature of the adverse reaction to the preferred drug _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)
☐ docetaxel ☐ conventional paclitaxel

_____

_____

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aetna®

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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.

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

Will Abraxane be used to treat any of the following? (please mark all that apply)

- ☐ **AIDS-related Kaposi sarcoma as subsequent therapy given with anti-retroviral therapy (ART)**
  - ☐ relapsed/refractory advanced, ☐ cutaneous, ☐ oral, ☐ visceral, OR ☐ nodal disease
- ☐ **Recurrent OR metastatic breast cancer**
  - ☐ Single agent for human epidermal growth factor receptor 2 (HER2)-negative disease OR
  - ☐ In combination with trastuzumab (Herceptin) for HER-2 positive recurrent or metastatic trastuzumab-exposed disease
    - ☐ with symptomatic visceral disease OR visceral crisis,
    - ☐ hormone receptor negative, OR
    - ☐ hormone receptor positive & endocrine therapy refractory
    - ☐ Substituted for either paclitaxel or docetaxel in persons who have experienced hypersensitivity reactions after receiving paclitaxel or docetaxel despite premedication, or for persons in whom standard hypersensitivity pre-medications are contraindicated
- ☐ **Cervical cancer as a single agent 2nd line therapy**
  - ☐ Local/regional recurrence OR ☐ distant metastases
- ☐ **Intrahepatic/Extrahepatic cholangiocarcinoma in combination with gemcitabine as primary treatment**
  - ☐ Unresectable disease OR ☐ metastatic disease
- ☐ **Cutaneous melanoma as a single agent second line/subsequent therapy with performance status of 0-2 for**
  - ☐ Unresectable disease OR ☐ metastatic disease
  - ☐ status post disease progression OR ☐ after maximum clinical benefit from BRAF targeted therapy
- ☐ **Endometrial Carcinoma**
  - ☐ Primary treatment as a single agent for endometrioid adenocarcinoma
    - ☐ Disease not suitable for primary surgery
      - ☐ that is limited to the uterus, ☐ with cervical involvement, OR ☐ extra-uterine disease
    - ☐ Pre-operatively for disease that is suitable for primary surgery with abdominal/pelvic confined disease
    - ☐ For distant metastases
  - ☐ Single agent therapy for endometrioid adenocarcinoma
    - ☐ Distant/isolated metastases ☐ disseminated metastases that have progressed on hormonal therapy OR
    - ☐ are grade 2, 3, or large volume disseminated metastases OR
    - ☐ local/regional recurrence in persons with gross upper abdominal residual disease
    - ☐ With sequential external beam radiation therapy (EBRT) for local/regional recurrence with disease
      - ☐ Confined to the vagina or pelvic lymph nodes ☐ in para-aortic or common iliac lymph nodes
    - ☐ Local/regional recurrent disease for
      - ☐ microscopic residual upper abdominal OR ☐ peritoneal disease
      - ☐ received prior external beam radiation therapy (EBRT) to the site of recurrence
    - ☐ Carcinosarcoma, clear cell carcinoma, serous carcinoma, or undifferentiated/dedifferentiated carcinoma
      - ☐ As primary treatment for disease not suitable for primary surgery
      - ☐ As additional treatment for disease suitable for primary surgery
        - ☐ With vaginal brachytherapy fro Stage IA disease ☐ For Stage IB-IV disease
  - ☐ Adjuvant treatment as single agent with histologic grade 3 tumors for
    - ☐ Stage IB disease with vaginal brachytherapy and/or sequential external beam radiation therapy (EBRT)
    - ☐ Stage II disease with sequential external beam radiation therapy (EBRT)
  - ☐ Adjuvant treatment as single agent for
    - ☐ Stage IIIA-IVA ☐ Stage IVB
- ☐ **Epithelial Ovarian Cancer for persistent or recurrent disease**
  - ☐ As a single agent ☐ With carboplatin for persons with confirmed taxane hypersensitivity
- ☐ **Fallopian tube cancer for persistent or recurrent disease**
  - ☐ As a single agent ☐ With carboplatin for persons with confirmed taxane hypersensitivity

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G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

☐ **Non-small-cell lung cancer (NSCLC) for recurrent or metastatic disease as a single agent for performance status 2 OR in combination with carboplatin for performance status 0-2**
- ☐ 1st Line therapy
  - ☐ EGFR, ALK, ROS1, BRAF, and PD-L1 negative or unknown ☐ BRAF V600E-mutation positive tumors
- ☐ Subsequent therapy for
  - ☐ BRAF V600E mutation positive tumors
  - ☐ EGFR mutation positive and prior erlotinib/afatinib/gefitinib/osimertinib therapy
  - ☐ ALK positive tumors and prior crizotinib/ceritinib/alectinib/brigatinib therapy
  - ☐ ROS1 rearrangement positive tumors and prior crizotinib therapy
  - ☐ PD-L1 positive (≥50%) tumor, EGFR, ALK, ROS1, and BRAF negative tumors and prior pembrolizumab therapy.

☐ **Non-small-cell lung cancer (NSCLC) when substituted for either paclitaxel or docetaxel in persons who have experienced hypersensitivity reactions after receiving paclitaxel or docetaxel despite premedication, or for persons in whom standard hypersensitivity premedications are contraindicated**

☐ **Pancreatic cancer in combination with gemcitabine**
- ☐ As neoadjuvant therapy
  - ☐ Biopsy positive borderline resectable disease OR ☐ resectable disease with high-risk features (ie, very highly elevated CA 19-9, large primary tumors, large regional lymph nodes, excessive weight loss, extreme pain)
- ☐ As first line chemotherapy or as induction therapy followed by chemoradiation in persons with good performance status (KPS greater than or equal to 70)
  - ☐ Without systemic metastases in locally advanced unresectable disease ☐ First-line therapy in metastatic disease
- ☐ As second-line therapy for persons with good performance status (KPS greater than or equal to 70)
  - ☐ For locally advanced unresectable /metastatic disease and disease progression following fluoropyrimidine-based therapy
  - ☐ Local recurrence in the pancreatic bed after resection OR ☐ For metastatic disease

☐ **Primary carcinoma of the urethra used as a single agent as subsequent systemic therapy for**
- ☐ Recurrent disease OR ☐ Metastatic disease

☐ **Primary peritoneal cancer for persistent disease or recurrence**
- ☐ in combination with carboplatin for persons with confirmed taxane hypersensitivity OR ☐ as a single agent

☐ **Upper genitourinary tract tumors used as a single agent as subsequent systemic therapy for metastatic disease**

☐ **Urothelial carcinoma of the prostate used as a single agent as subsequent systemic therapy for metastatic disease**

☐ **Uveal melanoma as a single agent therapy for**
- ☐ Metastatic OR ☐ Unresectable disease

For Continuation of Therapy: (clinical documentation required):

☐ Yes ☐ No Is this a continuation request a result of the patient receiving samples of Abraxane® (paclitaxel protein-bound particles)?

☐ Yes ☐ No Is the patient receiving benefit from therapy, defined as no evidence of unacceptable toxicity AND no evidence of 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.