Besponsa® (inotuzumab ozogamicin) 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:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

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/ADMINISTRATI6ON 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 Besponsa (inotuzumab ozogamicin): 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 Does the patient have a documented diagnosis of acute lymphoblastic leukemia (ALL)?

For Initiation Requests (Clinical documentation required):
☐ Yes ☐ No Is there documentation that the patient has B-cell precursor acute lymphoblastic leukemia (B-ALL)?
Please indicate the clinical setting in which the requested drug will be used: ☐ Relapsed ☐ Refractory ☐ As frontline (induction) therapy ☐ Other
☐ Yes ☐ No ☐ Unknown Is the tumor CD-22 positive as confirmed by testing or analysis to identify the CD22 protein on the surface of the B-cell?
Please indicate the Philadelphia chromosome status of the patient's disease:
☐ Philadelphia chromosome-positive (Ph+) disease
☐ Philadelphia chromosome-negative (Ph-) disease
☐ Unknown
Please indicate the requested regimen:
☐ Single agent
☐ In combination with cyclophosphamide, dexamethasone, vincristine, methotrexate, and cytarabine with or without blinatumomab
☐ In combination with a tyrosine kinase inhibitor (e.g., imatinib, dasatinib, nilotinib, bosutinib, ponatinib) for Philadelphia chromosome-positive disease
☐ Other
☐ Yes ☐ No Will the patient receive more than 6 treatment cycles of the requested drug?

Continued on next page

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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 Continuation Requests (clinical documentation required):

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

Please indicate the number of cycles the patient has already received: _____

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.