Kadcyla® (ado-trastuzumab) 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:	E-mail:	

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

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ 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 E-mail:		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: _____
Address: _____
☐ Administration code(s) (CPT): _____

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: ☐ **Kadcyla (ado-trastuzumab emtansine)**
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):
What is the human epidermal growth factor receptor 2 (HER2) status? ☐ HER2 positive ☐ HER2 negative ☐ Unknown

☐ **Breast cancer**
☐ Yes ☐ No Will the requested drug be used as a single agent?
☐ *For early breast cancer*
→ ☐ Yes ☐ No Will the requested drug be used as adjuvant treatment?
How many months has the patient received therapy with the requested medication? ____
☐ *For* ☐ *Metastatic disease* ☐ *Recurrent disease* ☐ *The disease had no response to preoperative systemic therapy*
→ What is the place in therapy in which the requested drug be used? ☐ First-line treatment ☐ Subsequent treatment
☐ *For Initial treatment of small asymptomatic brain metastases in breast cancer*

☐ **Non-small cell lung cancer**
Please indicate the clinical setting in which the requested drug will be used: ☐ Advanced disease ☐ Recurrent disease ☐ Metastatic disease
What is the place in therapy in which the requested drug be used? ☐ First-line treatment ☐ Subsequent treatment
☐ Yes ☐ No Will the requested drug be used as a single agent?

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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.

☐ **Salivary gland tumor**

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

Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Unresectable disease ☐ Metastatic disease ☐ Other

For Continuation Requests (clinical documentation required):

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

☐ Yes ☐ No Is the requested drug being used as adjuvant treatment of early breast cancer?

→ How many months of the requested medication has the patient 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.