Lumoxiti™ (moxetumomab pasudotox) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

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 #: _____
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 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: _____
☐ Administration code(s) (CPT): _____
Address: _____

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

E. PRODUCT INFORMATION

Request is for Lumoxiti (moxetumomab pasudotox): 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):

☐ **Hairy cell leukemia (HCL):**
Please indicate the patient's disease state: ☐ Relapsed disease ☐ Refractory disease ☐ Other: please explain: _____
How many cycles of treatment with Lumoxiti has the patient already received? ☐ Less than six ☐ Six or more

For Initiation Requests:

Please indicate how many systemic therapies the patient has previously received? ☐ 2 or more
☐ Less than 2

Please indicate the other systemic therapy the patient has received:
Name: _____ Date range of the therapy: ____/____/____ - ____/____/____
Name: _____ Date range of the therapy: ____/____/____ - ____/____/____
Name: _____ Date range of the therapy: ____/____/____ - ____/____/____

☐ Yes ☐ No Has the patient received prior treatment with a purine nucleoside analog?
→ Date range of the therapy: ____/____/____ - ____/____/____
☐ Yes ☐ No Will Lumoxiti be used as a single agent?

For Continuation Requests:

Please provide the start date of Lumoxiti (moxetumomab pasudotox): ____/____/____
☐ Yes ☐ No Has the patient experienced disease progression or unacceptable toxicity while on Lumoxiti (moxetumomab pasudotox)?
→ Please indicate: ☐ Disease progression ☐ Unacceptable toxicity

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.