Reblozyl® (luspatercept-aamt) 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/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 Reblozyl (luspatercept-aamt) 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 Initiation Requests (clinical documentation required for all requests):

Anemia with beta thalassemia:

☐ Yes ☐ No Does the patient have a diagnosis of hemoglobin S/β-thalassemia or alpha thalassemia?

☐ Yes ☐ No Has the diagnosis of beta thalassemia or hemoglobin E/beta-thalassemia been confirmed by hemoglobin electrophoresis, high- performance liquid chromatography (HPLC) or molecular genetic testing?

→ ☐ Yes ☐ No Are there chart notes or medical record documentation stating the patient's diagnosis of beta thalassemia or hemoglobin E/beta-thalassemia was previously confirmed by appropriate testing (e.g., hemoglobin electrophoresis or high-performance liquid chromatography [HPLC], molecular genetic testing)?

☐ Yes ☐ No Prior to starting treatment with the requested drug, does the patient have symptomatic anemia?

☐ Yes ☐ No Has the patient's pretreatment or pretransfusion hemoglobin (Hgb) level been drawn?

→ Please indicate the hemoglobin level: _____ grams per deciliter

☐ Yes ☐ No Did the patient require at least 6 red blood cell units to be transfused in the previous 24 weeks?

Anemia associated with myelodysplastic syndrome or myelodysplastic/myeloproliferative neoplasm or Anemia associated with hemoglobin E/beta-thalassemia

☐ Yes ☐ No Does the patient have one of the following: A) very low to intermediate risk myelodysplastic syndrome or B) myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)?

☐ Yes ☐ No Prior to starting treatment with the requested drug, does the patient have symptomatic anemia?

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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.

☐ Yes ☐ No Has the patient's pretreatment or pretransfusion hemoglobin (Hgb) level been drawn?

→ Please indicate the hemoglobin level: _____ grams per deciliter

☐ Yes ☐ No Has the patient been receiving regular red blood cell transfusions as defined by greater than or equal to 2 units per 8 weeks?

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

☐ Yes ☐ No Has the patient achieved or maintained a reduction in red blood cell transfusion burden?

☐ Yes ☐ No Has the patient experienced an unacceptable toxicity while taking the requested medication?

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.