# Rylaze™ (asparaginase erwinia chrysanthemi (recombinant)-rywn) Medication Precertification Request



**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

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

**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: | Email: | |
| Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms | | | Allergies: | |

## B. INSURANCE INFORMATION

| | |
|---|---|
| **Aetna Member ID #**: _____<br>**Group #**: _____<br>**Insured**: | Does patient have other coverage? ☐ Yes ☐ No<br>If yes, provide ID#: _____ Carrier Name: _____<br>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:** ☐ **Rylaze (asparaginase erwinia chrysanthemi (recombinant)-rywn)**
**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.

☐ Yes ☐ No Does the patient have a diagnosis of acute lymphoblastic leukemia (ALL) or lymphoblastic lymphoma (LBL)?
→ Please explain: ☐ acute lymphoblastic leukemia (ALL) ☐ lymphoblastic lymphoma (LBL)

**For Initiation Requests (clinical documentation required):**
☐ Yes ☐ No Has the patient developed hypersensitivity to E. coli-derived asparaginase (e.g., pegaspargase)?
☐ Yes ☐ No Will the requested drug used in conjunction with multi-agent chemotherapy?

**For Continuation Requests (clinical documentation required):**
☐ Yes ☐ No Is there evidence of unacceptable toxicity or 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.