Specialty 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** ☐ **Hematologist** ☐ **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

Drug request is for: ______________
Dose: ____________ **Frequency:** ____________ **Route**: ____________

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Diagnosis: ____________ Primary ICD Code: ____________ Secondary ICD Code: ____________

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

This form is for use ONLY where a drug specific specialty medication precertification request form does not exist.
For all requests (Clinical documentation must be submitted with all drug requests)

☐ Yes ☐ No Has the patient been treated with another medication for this diagnosis?
→ Please provide the name of the previous medication(s): ______________
Please provide the date range of previous treatment: ____/____/____ - ____/____/____
____/____/____ - ____/____/____
☐ Yes ☐ No Was treatment with this medication ineffective, not tolerated, or contraindicated?
→ Please select which one applies to the previous treatment: ☐ Ineffective ☐ Not tolerated ☐ Contraindicated
Please explain answer: ______________

☐ Yes ☐ No Has this condition been confirmed by diagnostic testing?
→ Please provide the diagnostic test name and date performed: Test name: ____________ Date: ____/____/____

Please provide any relevant laboratory data specific to this drug request (e.g. complete blood count, liver transaminase, bilirubin, TB testing, pregnancy test, genetic testing): Name of test(s): ______________
Test results: ______________
Date(s) of testing: ______________

Please list any other relevant information specific to this medication request: ______________
____
____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)* - Required clinical information must be completed for ALL precertification requests.

For oncology requests (must complete this section in addition to information above)

Please list current cancer stage: ______________________________

Please identify the current disease state: ☐ Progressive ☐ Relapsed ☐ Refractory ☐ Unresectable ☐ Metastatic ☐ Advanced

Please identify how the medication will be used: ☐ First line therapy ☐ Second line therapy ☐ Subsequent therapy

Will the medication be used as a single agent or in combination with another medication? ☐ Single agent ☐ In combination with another medication

→ If used in combination with another medication, list the medication here: ______________________________

☐ Yes ☐ No Is this medication FDA approved in this particular setting?

→ ☐ Yes ☐ No Is this medication recommended by NCCN in this particular setting?

→ Please select one of the following: ☐ NCCN Category 1 ☐ NCCN Category 2A ☐ NCCN Category 2B ☐ NCCN Category 3

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.