aetna™

MEDICARE FORM
Herceptin® (trastuzumab), Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk), Kadcyla® (ado-trastuzumab) and Perjeta® (pertuzumab) Precertification Request

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

For Virginia HMO SNP:
FAX: 1-833-280-5224
PHONE: 1-855-463-0933

For other lines of business:
Please use other form.

Note: Herceptin and Herceptin Hylecta are non-preferred. The preferred product is biosimilar trastuzumab.

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: _____

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:
Office Contact Name:		Phone:			

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:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Herceptin (trastuzumab)** ☐ **Perjeta (pertuzumab)** ☐ **Kadcyla (ado-trastuzumab emtansine)**
☐ **Herceptin Hylecta (trastuzumab and hyaluronidase-oysk)** ☐ **Kanjinti (trastuzumab-anns)**
Dose: _____ **Frequency:** _____ **HCPCS Code:** _____

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):
☐ Yes ☐ No Does the patient have HER2 protein overexpression documented by one of the following?
→ **Check all that apply**:
☐ Immunohistochemistry (IHC) Assay level of 3+
→ Results _____ Date of Test: ____/____/____
☐ Positive Fluorescent in situ hybridization (FISH) HER2 gene copy of greater than 6 signals/nucleus
→ Results _____ Date of Test: ____/____/____
☐ Positive Fluorescent in situ hybridization (FISH) HER2 gene/ chromosome 17 ratio greater than or equal to 2.0
→ Results _____ Date of Test: ____/____/____

Note: Herceptin and Herceptin Hylecta are non-preferred. The preferred product is biosimilar trastuzumab.
☐ Yes ☐ No Has the patient had prior therapy with Herceptin (trastuzumab) or Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) within the last 365 days?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to biosimilar trastuzumab?
Please explain if there are any other medical reason(s) that the patient cannot use biosimilar trastuzumab.

HERCEPTIN (trastuzumab):
☐ **Esophageal adenocarcinoma** ☐ **Gastric adenocarcinoma** ☐ **Esophageal-gastric junction adenocarcinoma**
☐ Yes ☐ No Will Herceptin (trastuzumab) be used as palliative therapy?
☐ Yes ☐ No Will Herceptin (trastuzumab) be used in combination with systemic chemotherapy?
→ Please provide the name of the systemic chemotherapy: _____

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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.

Endometrial carcinoma

☐ Yes ☐ No Does the patient have advanced (stage III/IV) disease?
☐ Yes ☐ No Does the patient have a documented diagnosis of uterine serous carcinoma?
☐ Yes ☐ No Does the patient have recurrent disease?
☐ Yes ☐ No Will Herceptin (trastuzumab) be used in combination with carboplatin and paclitaxel?

Salivary gland tumors

☐ Yes ☐ No Does the patient have recurrent disease with distant metastases?
Please indicate how Herceptin (trastuzumab) will be used: ☐ single agent ☐ Other: Please explain: _____
☐ in combination with systemic chemotherapy: Name of systemic chemotherapy: _____

HER2 positive breast cancer

☐ Yes ☐ No Does the patient have recurrent, metastatic, stage IV disease or leptomeningeal metastases from breast cancer (as intracerebrospinal fluid treatment)? ☐ recurrent disease ☐ metastatic disease ☐ stage IV disease
☐ leptomeningeal metastases from breast cancer (as intracerebrospinal fluid treatment)

→ ☐ Yes ☐ No Will Herceptin (trastuzumab) be used as pre-operative (neoadjuvant) systemic therapy?
→ Please select in which of the following settings Herceptin (trastuzumab) will be used:
☐ Node-positive disease likely to become node-negative with pre-operative systemic therapy
☐ Locally advanced disease ☐ Individuals who fulfill criteria for breast-conserving surgery except for tumor size
☐ None of the above

☐ Yes ☐ No Will Herceptin (trastuzumab) be used as adjuvant therapy?
☐ Yes ☐ No Will Herceptin (trastuzumab) be used as part of a complete treatment regimen?

HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-oysk):

HER2 positive breast cancer

Please select which of the following applies to the patient's disease stage:
☐ Early stage HER2-overexpressing breast cancer
→ ☐ Yes ☐ No Will Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) be used as adjuvant therapy?
☐ Metastatic HER2-overexpressing breast cancer
☐ Other

PERJETA (pertuzumab) with HERCEPTIN (trastuzumab):

***(please ensure dosing and instructions for both drugs are documented in section E)* HER2 positive breast cancer**

Please select which type of treatment Perjeta (pertuzumab) and Herceptin (trastuzumab) is being used for:
☐ Adjuvant therapy
→ ☐ Yes ☐ No Is the patient's disease node-positive or at high-risk for recurrence?
→ Please select: ☐ Node-positive ☐ At high-risk for recurrence ☐ Other: _____
☐ Preoperative (neoadjuvant) therapy
→ Please select in which of the following settings Perjeta (pertuzumab) with Herceptin (trastuzumab) will be used:
☐ Node-positive disease likely to become node-negative with pre-operative systemic therapy
☐ Individuals who desire breast preservation and fulfill criteria for breast-conserving surgery except for tumor size
☐ Locally advanced disease ☐ None of the above
☐ Other
→ Please indicate which applies to the patient's disease: ☐ Recurrent disease ☐ Metastatic disease
☐ Yes ☐ No Does the patient have symptomatic visceral disease or visceral crisis?
→ Please specify: ☐ Symptomatic visceral disease ☐ Visceral crisis

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

KADCYLA (ado-trastuzumab emtansine):

☐ Yes ☐ No Does the patient have a documented diagnosis of HER2-positive non-small cell lung cancer?
- ☐ Yes ☐ No Is the patient being treated for HER2-positive recurrent or metastatic breast cancer?
  - ☐ Yes ☐ No Will Kadcyla (ado-trastuzumab emtansine) be used as adjuvant systemic therapy?
  - ☐ Yes ☐ No Has the patient received neoadjuvant therapy containing a taxane (with or without anthracycline) and trastuzumab?
    Please provide the date range of use: ____/____/____ to ____/____/____
  - ☐ Yes ☐ No Does the patient have a residual disease after receiving neoadjuvant therapy?
  - Please indicate which applies: ☐ recurrent breast cancer ☐ metastatic breast cancer
  - ☐ Yes ☐ No Does the patient have symptomatic visceral disease or visceral crisis?
    - Please indicate the type of breast cancer: ☐ Hormone receptor- negative ☐ Hormone receptor-positive ☐ Unknown ☐ Other
    - ☐ Yes ☐ No Is the breast cancer refractory to endocrine therapy?
      - Please select which of the following endocrine therapy the patient is refractory to:
        - ☐ Nonsteroidal aromatase inhibitors (anastrozole and letrozole)
        - ☐ Steroidal aromastase inhibitors (exemestane)
        - ☐ Estrogen receptor (ER) antagonists (tamoxifen or toremifene)
        - ☐ ER down-regulators (fulvestrant) ☐ High-dose estrogen (ethinyl estradiol)
        - ☐ Androgens (fluoxymesterone) ☐ Other: Please explain: _____
    - Please specify: ☐ symptomatic visceral disease ☐ visceral crisis
  - ☐ Yes ☐ No Will Kadcyla (ado-trastuzumab emtansine) be used as a single agent?
- ☐ Yes ☐ No Will Kadcyla (ado-trastuzumab emtansine) be used concomitantly with Herceptin (trastuzumab), Tykerb (lapatinib), or Perjeta (pertuzumab)?

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Has the patient experienced disease progression or unacceptable toxicity while on HER2 therapy?
- Please indicate: ☐ Disease progression ☐ Unacceptable toxicity

HERCEPTIN (trastuzumab):

For HER2-positive breast cancer only:

☐ Yes ☐ No Is there clinical evidence of distant metastatic disease?
- Please provide initial start date: ____/____/____

HERCEPTIN HYLECTA (trastuzumab and hyaluronidase-oysk):

☐ Yes ☐ No Will Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) be used in adjuvant settings?
- Please provide the initial start date: ____/____/____

PERJETA (pertuzumab) with HERCEPTIN (trastuzumab):

☐ Yes ☐ No Is there clinical evidence of distant metastatic disease?
- Please provide initial start date: ____/____/____

KADCYLA (ado-trastuzumab emtansine):

☐ Yes ☐ No Is Kadcyla (ado-trastuzumab emtansine) being used concomitantly with Herceptin (trastuzumab), Tykerb (lapatinib), or Perjeta (pertuzumab)?

☐ Yes ☐ No Is there clinical evidence of metastatic disease?
- Please provide initial start date: ____/____/____

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.