# Enhertu® (fam-trastuzumab deruxtecan-nxki) 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 Enhertu (fam-trastuzumab deruxtecan-nxki) 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):**

☐ **Breast cancer**
- ☐ Yes ☐ No Will requested drug be used as a single agent?
- Please indicate which of the following applies to the patient's disease:
  - ☐ Human epidermal growth factor receptor 2 (HER2) positive breast cancer
    - → Please indicate the clinical setting in which the requested drug will be used:
      - ☐ Recurrent disease ☐ Metastatic disease ☐ Unresectable disease
      - ☐ The disease had no response to preoperative systemic therapy ☐ Other
  - ☐ HER2-low (IHC 1+ or IHC 2+/ISH-) breast cancer
    - → Please indicate the clinical setting in which the requested drug will be used:
      - ☐ The disease had no response to preoperative systemic therapy ☐ Recurrent unresectable disease ☐ Metastatic disease ☐ Other
      - ☐ Yes ☐ No Has the patient tried at least one prior chemotherapy in the metastatic setting?
        - → ☐ Yes ☐ No Has the patient developed recurrence during or within 6 months of completing adjuvant chemotherapy?
  - ☐ Unknown HER2 status

***Continued on next page***

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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.**

☐ **Colorectal cancer (including appendiceal and adenocarcinoma)**
- ☐ Yes ☐ No ☐ Unknown Does the patient have HER2- amplified disease?
- ☐ Yes ☐ No ☐ Unknown Does the patient have RAS and BRAF wild-type disease?
- ☐ Yes ☐ No Will requested drug be used as a single agent?
- ☐ Yes ☐ No Will the requested drug be used as subsequent therapy for progression of advanced or metastatic disease?

☐ **Esophageal, gastric or gastroesophageal junction adenocarcinoma**

Please indicate the patient's human epidermal growth factor receptor 2 (HER2) status: ☐ HER2 positive ☐ HER2 negative ☐ Unknown

Please indicate the clinical setting in which the requested drug will be used:

☐ Locally advanced disease ☐ Recurrent disease ☐ Metastatic disease ☐ Other

Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment

☐ Yes ☐ No Will requested drug be used as a single agent?

☐ **Non-small cell lung cancer**
- ☐ Yes ☐ No ☐ Unknown Is the patient's disease positive for HER2 (ERBB2) mutations?
- ☐ Yes ☐ No Will requested drug be used as a single agent?

Please indicate the clinical setting in which the requested drug will be used: ☐ Advanced disease ☐ Recurrent disease ☐ Metastatic disease ☐ Unresectable disease ☐ Other

Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment

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

☐ Yes ☐ No Has the patient experienced disease progression or an unacceptable toxicity 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.