MEDICARE FORM

Herceptin® (trastuzumab), Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk), Herzuma (trastuzumab-pkrb), Kadcyla® (ado-trastuzumab), Kanjinti (trastuzumab-anns), Ogivri (trastuzumab-dkst), Ontruzant (trastuzumab-dttb), Perjeta® (pertuzumab) and Trazimera (trastuzumab-qyyp) Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Herceptin, Herceptin Hylecta, Herzuma, Ogivri, and Ontruzant are non-preferred. The preferred biosimilar products are Kanjinti and Trazimera. Perjeta is also non-preferred and Phesgo is preferred.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to:
Phone: 1-866-503-0857 **(TTY: 711)**
Fax: 1-844-268-7263
Availity: https://www.aetna.com/health-care-professionals/resource-center/availity.html

For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:
Phone: 1-855-463-0933
Fax: 1-833-280-5224
Availity: https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal

For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to:
Phone: 1-844-362-0934
Fax: 1-833-322-0034
Availity: https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html

For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to:
Phone: 1-866-600-2139
FAX: 1-855-320-8445
Availity: https://www.aetnabetterhealth.com/illinois/providers/portal

For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to:
Phone: 1-855-364-0974
Fax: 1-855-734-9389
Availity: https://www.aetnabetterhealth.com/ohio/providers/portal

For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to:
Phone: 1-855-676-5772
Fax: 1-844-241-2495
Availity: https://www.aetnabetterhealth.com/michigan/providers/portal.html

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MEDICARE FORM

Herceptin® (trastuzumab), Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk), Herzuma (trastuzumab-pkrb), Kadcyla® (ado-trastuzumab), Kanjinti (trastuzumab-anns), Ogivri (trastuzumab-dkst), Ontruzant (trastuzumab-dttb), Perjeta® (pertuzumab) and Trazimera (trastuzumab-qyyp) Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

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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: _____

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:	

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: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Herceptin (trastuzumab)** ☐ **Perjeta (pertuzumab)** ☐ **Kadcyla (ado-trastuzumab emtansine)** ☐ **Ogivri (trastuzumab-dkst)**
☐ **Ontruzant (trastuzumab-dttb)** ☐ **Herzuma (trastuzumab-pkrb)** ☐ **Herceptin Hylecta (trastuzumab and hyaluronidase-oysk)**
☐ **Kanjinti (trastuzumab-anns)** ☐ **Trazimera (trastuzumab-qyyp)**

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: ____/____/____

Continued on next page

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MEDICARE FORM

Herceptin® (trastuzumab), Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk), Herzuma (trastuzumab-pkrb), Kadcyla® (ado-trastuzumab), Kanjinti (trastuzumab-anns), Ogivri (trastuzumab-dkst), Ontruzant (trastuzumab-dttb), Perjeta® (pertuzumab) and Trazimera (trastuzumab-qyyp) Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Herceptin, Herceptin Hylecta, Herzuma, Ogivri, and Ontruzant are non-preferred. The preferred biosimilar products are Kanjinti and Trazimera. Perjeta is also non-preferred and Phesgo is preferred.

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.

For Initiation Requests (clinical documentation required):

Note: Herceptin, Herceptin Hylecta, Herzuma, Ogivri, and Ontruzant are non-preferred. The preferred biosimilar products are Kanjinti, and Trazimera. Perjeta is also non-preferred and Phesgo is preferred.
Preferred products may vary based on indication.

☐ Yes ☐ No Has the patient had prior therapy with the requested product within the last 365 days?

For trastuzumab requests:

☐ No Has the patient had a trial and failure of any of the following Herceptin biosimilars? (if yes, select all that apply below)
- ☐ Kanjinti (trastuzumab-anns) ☐ Trazimera (trastuzumab-qyyp)
- → When was the member's trial and failure of the preferred biosimilar? _____
- → Please describe the nature of the failure of the preferred biosimilar _____

☐ No Has the patient had an adverse reaction to any of the following Herceptin biosimilars? (if yes, select all that apply below)
- ☐ Kanjinti (trastuzumab-anns) ☐ Trazimera (trastuzumab-qyyp)
- → When was the member's adverse reaction to the preferred biosimilar? _____
- → Please describe the nature of the adverse reaction to the preferred biosimilar _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following preferred biosimilar products when indicated for the patient's diagnosis (select all that apply)

☐ Kanjinti (trastuzumab-anns) ☐ Trazimera (trastuzumab-qyyp)

_____

For Perjeta requests:

☐ Yes ☐ No Has the patient had a trial and failure of Phesgo (pertuzumab/trastuzumab/hyaluronidase-zzxf)?
- → When was the member's trial and failure of Phesgo? _____
- → Please describe the nature of the failure of Phesgo _____

☐ Yes ☐ No Has the patient had an adverse reaction to Phesgo (pertuzumab/trastuzumab/hyaluronidase-zzxf)?
- → When was the member's adverse reaction to Phesgo? _____
- → Please describe the nature of the adverse reaction to Phesgo _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use Phesgo (pertuzumab/trastuzumab/hyaluronidase-zzxf) when indicated for the patient's diagnosis.

_____

For All Requests (clinical documentation required):

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: _____

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?

Continued on next page

MEDICARE FORM

Herceptin® (trastuzumab), Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk), Herzuma (trastuzumab-pkrb), Kadcyla® (ado-trastuzumab), Kanjinti (trastuzumab-anns), Ogivri (trastuzumab-dkst), Ontruzant (trastuzumab-dttb), Perjeta® (pertuzumab) and Trazimera (trastuzumab-qyyp) Precertification Request

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For other lines of business:
Please use commercial form.

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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.

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

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
→ 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: ____/____/____

Continued on next page

MEDICARE FORM

Herceptin® (trastuzumab), Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk), Herzuma (trastuzumab-pkrb), Kadcyla® (ado-trastuzumab), Kanjinti (trastuzumab-anns), Ogivri (trastuzumab-dkst), Ontruzant (trastuzumab-dttb), Perjeta® (pertuzumab) and Trazimera (trastuzumab-qyyp) Precertification Request

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

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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.

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.