# Adcetris® (brentuximab vedotin) Injectable 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** ☐ **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: _____
Phone: _____ Fax: _____
Address: _____
**TIN:** _____ PIN: _____

## E. PRODUCT INFORMATION

**Request is for Adcetris (brentuximab vedotin): 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 All Requests (clinical documentation required):**

☐ Yes ☐ No Has testing or analysis been completed which confirms CD30 expression on the surface of the cell?
→ **ACTION REQUIRED: If 'Yes', please attach supporting laboratory report or medical record indicating CD30 positive disease.**

**For Initiation Requests (clinical documentation required):**

**Adult T-cell leukemia/lymphoma**

Please indicate the requested regimen:
☐ The requested drug will be used as a single agent
→ Please indicate the place in therapy the requested drug will be used: ☐ initial therapy ☐ subsequent therapy
☐ The requested drug will be used in combination with cyclophosphamide, doxorubicin, and prednisone
☐ Other: please explain: _____

**AIDS-related B-cell lymphoma (CD30+ AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma), Diffuse large B-cell lymphoma or High Grade B-cell lymphoma**

Please select the indication being treated:
☐ AIDS-related B-cell lymphoma (CD30+ AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus-8 (HHV8) positive diffuse large B-cell lymphoma) ☐ Diffuse large B-cell lymphoma ☐ High-grade B-cell lymphomas
Please indicate the place in therapy the requested drug will be used: ☐ initial therapy ☐ subsequent therapy
☐ Yes ☐ No Is the patient a candidate for transplant?

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

**Breast implant associated anaplastic large cell lymphoma, Cutaneous anaplastic large cell lymphoma, Systemic anaplastic large cell lymphoma (ALCL)**

Please select the indication being treated: ☐ Breast implant associated anaplastic large cell lymphoma
☐ Cutaneous anaplastic large cell lymphoma ☐ Systemic anaplastic large cell lymphoma (ALCL)

What is the requested regimen?
☐ The requested drug will be used as a single agent
☐ The requested drug will be used in combination with cyclophosphamide, doxorubicin, and prednisone
☐ Other: please explain: _____

**Classical Hodgkin lymphoma**

What is the requested regimen?
☐ The requested drug will be used as a single agent
☐ The requested drug will be used in combination with doxorubicin, vinblastine, dacarbazine
☐ The requested drug will be used in combination with bendamustine
→ Please indicate the place in therapy the requested drug will be used: ☐ initial therapy ☐ subsequent therapy
☐ The requested drug will be used in combination with dacarbazine
☐ The requested drug will be used in combination with nivolumab
→ ☐ Yes ☐ No Is the disease relapsed or refractory?
☐ The requested drug will be used in combination with gemcitabine
→ ☐ Yes ☐ No Is the disease relapsed or refractory?
☐ Other: please explain: _____

**Extranodal NK/T-cell lymphoma (nasal type)**

☐ Yes ☐ No Will the requested drug be used as a single agent?
☐ Yes ☐ No Is the disease relapsed or refractory?
☐ Yes ☐ No Has the patient had an inadequate response to asparaginase-based therapy (e.g., pegaspargase)?
→ ☐ Yes ☐ No Does the patient have a contraindication to asparaginase-based therapy (e.g., pegaspargase)?

**Hepatosplenic T-cell lymphoma**

☐ Yes ☐ No Will the requested drug be used as a single agent?
→ ☐ Yes ☐ No Will the requested drug be used in combination with cyclophosphamide, doxorubicin, and prednisone?
→ ☐ Other treatment regimen: please explain: _____

How many previous lines of primary treatment regimens has the patient received? ☐ Zero ☐ One ☐ Two or more

**Histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma, Histologic transformation of follicular lymphoma to diffuse large B-cell lymphoma**

Please select the indication being treated: ☐ Histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma
☐ Histologic transformation of follicular lymphoma to diffuse large B-cell lymphoma

How many previous chemoimmunotherapy regimens has the patient received? ☐ Zero ☐ One ☐ Two or more

**Lymphomatoid papulosis (LyP)**

☐ Yes ☐ No Will requested drug will be used be used as a single-agent?
☐ Yes ☐ No Is the patient's disease relapsed or refractory?

**Mycosis fungoides/Sezary syndrome**

Please select which of the following the patient is being treated for: ☐ Mycosis fungoides ☐ Sezary syndrome

**Monomorphic post-transplant lymphoproliferative disorders (B-cell type)**

Please indicate the place in therapy the requested drug will be used: ☐ initial therapy ☐ subsequent therapy

**Monomorphic post-transplant lymphoproliferative disorders (T-cell type)**

☐ Yes ☐ No Will the requested drug be used in combination with cyclophosphamide, doxorubicin, and prednisone?

**Peripheral T-cell lymphoma (PTCL) [including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, or follicular T-cell lymphoma], Angioimmunoblastic T-cell lymphoma**

Please select the indication being treated:
☐ Peripheral T-cell lymphoma (PTCL) [including the following subtypes: anaplastic large cell lymphoma, peripheral T-cell lymphoma not otherwise specified, angioimmunoblastic T-cell lymphoma, enteropathy associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma with TFH phenotype, or follicular T-cell lymphoma] ☐ Angioimmunoblastic T-cell lymphoma

Please indicate the requested regimen:
☐ The requested drug will be used as a single agent
→ Please indicate the place in therapy the requested drug will be used: ☐ subsequent therapy ☐ palliative therapy ☐ other
☐ The requested drug will be used in combination with cyclophosphamide, doxorubicin, and prednisone
☐ Other: please explain: _____

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

**For Continuation Requests (clinical documentation required):**

☐ Yes ☐ No Has the patient experienced disease progression or 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.