



**FYARRO™ (sirolimus protein-bound particles for injectable suspension) (albumin-bound) Medication Precertification Request**

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(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:		DOB:	
Address:			City:		State: ZIP:
Home Phone:		Work Phone:		Cell Phone: Email:	
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms				Allergies:	

**B. INSURANCE INFORMATION**

Aetna Member ID #: _____		Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Group #: _____		If yes, provide ID#: _____ Carrier Name: _____	
Insured: _____		Insured: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:	

**C. PRESCRIBER INFORMATION**

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:		State: ZIP:
Phone:		Fax:		St Lic #:	NPI #: DEA #: UPIN:
Provider Email:			Office Contact Name:		Phone:
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Other: _____					

**D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION**

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	<b>Dispensing Provider/Pharmacy: Patient Selected choice</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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**E. PRODUCT INFORMATION**

Request is for: <input type="checkbox"/> FYARRO (sirolimus protein-bound particles for injectable suspension) (albumin-bound)	
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: _____
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**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 a diagnosis of malignant perivascular epithelioid cell tumor (PEComa)?

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

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

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

☐ Locally advanced unresectable disease ☐ Metastatic disease ☐ Other

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

☐ Yes ☐ No Is there evidence of unacceptable toxicity or disease progression 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.