Reblozyl® (luspatercept-aamt) 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:
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 Reblozyl (luspatercept-aamt) 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):

Anemia with beta thalassemia:

☐ Yes ☐ No Does the patient have a diagnosis of hemoglobin S/β-thalassemia or alpha thalassemia?
☐ Yes ☐ No Does the patient have a diagnosis of beta thalassemia (β-thalassemia) or hemoglobin E/β-thalassemia (β-thalassemia with mutation and/or multiplication of alpha globin is allowed)?
☐ Yes ☐ No Has the diagnosis been confirmed by hemoglobin electrophoresis, high-performance liquid chromatography (HPLC) or molecular genetic testing?
☐ Yes ☐ No Did the patient require at least 6 red blood cell units to be transfused in the previous 24 weeks?
☐ Yes ☐ No Does the patient have symptomatic anemia?
☐ Yes ☐ No Has the patient's pretreatment or pretransfusion hemoglobin been drawn?
→ Please indicate the hemoglobin level: _____ grams per deciliter

Anemia associated with myelodysplastic syndrome or myelodysplastic/myeloproliferative neoplasm

☐ Yes ☐ No Does the patient have low to intermediate risk myelodysplastic syndrome or myelodysplastic/myeloproliferative neoplasm?
☐ Yes ☐ No Prior to starting the requested drug, does the patient have symptomatic anemia?
☐ Yes ☐ No Has the patient's pretreatment or pretransfusion hemoglobin been drawn?
→ Please indicate the hemoglobin level: _____ grams per deciliter

Continued on next page

Reblozyl® (luspatercept-aamt) 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:
Please Use Medicare Request Form

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.

☐ Yes ☐ No Has the patient been receiving regular red blood cell transfusions as defined by greater than or equal to 2 units per 8 weeks?

Please indicate the percentage of ring sideroblasts:

- ☐ Greater than or equal to 15%
- ☐ Greater than or equal to 5% and less than 15%
  - → ☐ Yes ☐ No Does the patient have an SF3B1 mutation?
- ☐ Less than 5%
- ☐ Unknown

☐ Yes ☐ No Has the patient's pretreatment serum erythropoietin been drawn?

→ Please indicate the serum erythropoietin level: _____

☐ Yes ☐ No Has the patient previously responded to the combination of any erythropoiesis-stimulating agent (ESA) and granulocyte-colony stimulating factor (G-CSF)?

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

☐ Yes ☐ No Has the patient achieved or maintained a reduction in red blood cell transfusion burden?

☐ Yes ☐ No Has the patient experienced any unacceptable toxicity while taking the requested medication?

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.