# bortezomib-VELCADE® 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: | | 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 #**: _____
**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:** ☐ **bortezomib** ☐ **VELCADE** **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 for all requests):**

Please indicate the patient's Body Surface Area (BSA): ____$m^2$
☐ Yes ☐ No Will the patient's dose exceed 1.6 $mg/m^2$?
☐ Yes ☐ No Does the patient require more than 7 doses per 30-day period?

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

☐ **Acute lymphoblastic leukemia**
Please indicate the clinical setting in which the requested medication will be used: ☐ Relapsed disease ☐ Refractory disease ☐ Other

☐ **Adult T-cell leukemia/lymphoma**
☐ Yes ☐ No Will the requested medication be used as a single agent?
Please indicate the place in therapy in which the requested medication will be used: ☐ First-line therapy ☐ Subsequent therapy

☐ **Antibody mediated rejection of solid organ**

☐ **Classic Hodgkin Lymphoma**
Please indicate the clinical setting in which the requested medication will be used: ☐ Relapsed disease ☐ Refractory disease ☐ Other

☐ **Follicular lymphoma**
Please indicate the clinical setting in which the requested medication will be used: ☐ Relapsed disease ☐ Refractory disease ☐ Other

☐ **Kaposi sarcoma**
Please indicate the place in therapy in which the requested medication will be used: ☐ First-line therapy ☐ Subsequent therapy

☐ **Mantle cell lymphoma**

☐ **Multicentric Castleman disease**
Please indicate the place in therapy in which the requested medication will be used: ☐ First-line therapy ☐ Subsequent therapy

☐ **Multiple myeloma**

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|---|---|---|---|
| | | | |

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

☐ **POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) Syndrome**
☐ Yes ☐ No Will the requested medication be used in combination with dexamethasone?

☐ **Systemic light chain amyloidosis**

☐ **Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma**

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

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