



# MEDICARE FORM

## Abraxane® (paclitaxel protein-bound particles) Injectable Medication Precertification Request

Page 1 of 3

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

For New Jersey HMO D-SNP:  
FAX: 1-833-322-0034  
PHONE: 1-844-362-0934

For other lines of business:  
Please use other form.

Note: Abraxane and generic paclitaxel (protein bound) are non-preferred. The preferred products are docetaxel or paclitaxel. Docetaxel and paclitaxel do not require precertification.

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:		E-mail:	
Current Weight: ____ lbs or ____ kgs		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: _____

### 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 E-mail:		Office Contact Name:		Phone:	

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

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

### E. PRODUCT INFORMATION

Request is for: Abraxane (paclitaxel protein-bound): 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.

Note: Abraxane and generic paclitaxel (protein bound) are non-preferred. The preferred products are docetaxel or paclitaxel. Docetaxel and paclitaxel do not require precertification.

Yes  No Has the patient had prior therapy with Abraxane (paclitaxel protein-bound) within the last 365 days?  
 Yes  No Has the patient had a trial and failure, intolerance, or contraindication to docetaxel or conventional paclitaxel?  
Please explain if there are any medical reason(s) that the patient cannot use docetaxel or conventional paclitaxel:  
\_\_\_\_\_  
\_\_\_\_\_

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

Will Abraxane be used to treat any of the following? (please mark all that apply)

- AIDS-related Kaposi sarcoma as subsequent therapy given with anti-retroviral therapy (ART)**
  - relapsed/refractory advanced,  cutaneous,  oral,  visceral, OR  nodal disease
- Recurrent OR metastatic breast cancer**
  - Single agent for human epidermal growth factor receptor 2 (HER2)-negative disease OR
  - In combination with trastuzumab (Herceptin) for HER-2 positive recurrent or metastatic trastuzumab-exposed disease
    - with symptomatic visceral disease OR visceral crisis,
    - hormone receptor negative, OR
    - hormone receptor positive & endocrine therapy refractory
    - Substituted for either paclitaxel or docetaxel in persons who have experienced hypersensitivity reactions after receiving paclitaxel or docetaxel despite premedication, or for persons in whom standard hypersensitivity pre-medications are contraindicated



# MEDICARE FORM

## Abraxane® (paclitaxel protein-bound particles) Injectable Medication Precertification Request

Page 2 of 3

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

For New Jersey HMO D-SNP:  
FAX: 1-833-322-0034  
PHONE: 1-844-362-0934

For other lines of business:  
Please use other form.

Note: Abraxane and generic paclitaxel (protein bound) are non-preferred. The preferred products are docetaxel or paclitaxel. Docetaxel and paclitaxel do not require precertification.

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.

- Cervical cancer as a single agent 2nd line therapy**
  - Local/regional recurrence OR  distant metastases
- Intrahepatic/Extrahepatic cholangiocarcinoma in combination with gemcitabine as primary treatment**
  - Unresectable disease OR  metastatic disease
- Cutaneous melanoma as a single agent second line/subsequent therapy with performance status of 0-2 for**
  - Unresectable disease OR  metastatic disease
  - status post disease progression OR  after maximum clinical benefit from BRAF targeted therapy
- Endometrial Carcinoma**
  - Primary treatment as a single agent for endometrioid adenocarcinoma
    - Disease not suitable for primary surgery
      - that is limited to the uterus,  with cervical involvement, OR  extra-uterine disease
    - Pre-operatively for disease that is suitable for primary surgery with abdominal/pelvic confined disease
    - For distant metastases
  - Single agent therapy for endometrioid adenocarcinoma
    - Distant/isolated metastases  disseminated metastases that have progressed on hormonal therapy OR
    - are grade 2, 3, or large volume disseminated metastases OR
    - local/regional recurrence in persons with gross upper abdominal residual disease
    - With sequential external beam radiation therapy (EBRT) for local/regional recurrence with disease
      - Confined to the vagina or pelvic lymph nodes  in para-aortic or common iliac lymph nodes
    - Local/regional recurrent disease for
      - microscopic residual upper abdominal OR  peritoneal disease
      - received prior external beam radiation therapy (EBRT) to the site of recurrence
    - Carcinosarcoma, clear cell carcinoma, serous carcinoma, or undifferentiated/dedifferentiated carcinoma
      - As primary treatment for disease not suitable for primary surgery
      - As additional treatment for disease suitable for primary surgery
        - With vaginal brachytherapy for Stage IA disease  For Stage IB-IV disease
  - Adjuvant treatment as single agent with histologic grade 3 tumors for
    - Stage IB disease with vaginal brachytherapy and/or sequential external beam radiation therapy (EBRT)
    - Stage II disease with sequential external beam radiation therapy (EBRT)
  - Adjuvant treatment as single agent for
    - Stage IIIA-IVA  Stage IVB
- Epithelial Ovarian Cancer for persistent or recurrent disease**
  - As a single agent  With carboplatin for persons with confirmed taxane hypersensitivity
- Fallopian tube cancer for persistent or recurrent disease**
  - As a single agent  With carboplatin for persons with confirmed taxane hypersensitivity
- Non-small-cell lung cancer (NSCLC) for recurrent or metastatic disease as a single agent for performance status 2 OR in combination with carboplatin for performance status 0-2**
  - 1st Line therapy
    - EGFR, ALK, ROS1, BRAF, and PD-L1 negative or unknown  BRAF V600E-mutation positive tumors
  - Subsequent therapy for
    - BRAF V600E mutation positive tumors
    - EGFR mutation positive and prior erlotinib/afatinib/gefitinib/osimertinib therapy
    - ALK positive tumors and prior crizotinib/ceritinib/alectinib/brigatinib therapy
    - ROS1 rearrangement positive tumors and prior crizotinib therapy
    - PD-L1 positive (≥50%) tumor, EGFR, ALK, ROS1, and BRAF negative tumors and prior pembrolizumab therapy.
- Non-small-cell lung cancer (NSCLC) when substituted for either paclitaxel or docetaxel in persons who have experienced hypersensitivity reactions after receiving paclitaxel or docetaxel despite premedication, or for persons in whom standard hypersensitivity premedications are contraindicated**

Continued on next page



# MEDICARE FORM

## Abraxane® (paclitaxel protein-bound particles) Injectable Medication Precertification Request

Page 3 of 3

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

For New Jersey HMO D-SNP:

FAX: 1-833-322-0034

PHONE: 1-844-362-0934

For other lines of business:

Please use other form.

**Note: Abraxane and generic paclitaxel (protein bound) are non-preferred. The preferred products are docetaxel or paclitaxel. Docetaxel and paclitaxel do not require precertification.**

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
--------------------	-------------------	---------------	-------------

**G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.**

- Pancreatic cancer in combination with gemcitabine**
  - As neoadjuvant therapy
    - Biopsy positive borderline resectable disease OR  resectable disease with high-risk features (ie, very highly elevated CA 19-9, large primary tumors, large regional lymph nodes, excessive weight loss, extreme pain)
  - As first line chemotherapy or as induction therapy followed by chemoradiation in persons with good performance status (KPS greater than or equal to 70)
    - Without systemic metastases in locally advanced unresectable disease  First-line therapy in metastatic disease
  - As second-line therapy for persons with good performance status (KPS greater than or equal to 70)
    - For locally advanced unresectable /metastatic disease and disease progression following fluoropyrimidine-based therapy
    - Local recurrence in the pancreatic bed after resection OR  For metastatic disease
- Primary carcinoma of the urethra used as a single agent as subsequent systemic therapy for**
  - Recurrent disease OR  Metastatic disease
- Primary peritoneal cancer for persistent disease or recurrence**
  - in combination with carboplatin for persons with confirmed taxane hypersensitivity OR  as a single agent
- Upper genitourinary tract tumors used as a single agent as subsequent systemic therapy for metastatic disease**
- Urothelial carcinoma of the prostate used as a single agent as subsequent systemic therapy for metastatic disease**
- Uveal melanoma as a single agent therapy for**
  - Metastatic OR  Unresectable disease

**For Continuation of Therapy: (clinical documentation required):**

- Is this a continuation request a result of the patient receiving samples of Abraxane® (paclitaxel protein-bound particles)?  Yes  No
- Is there clinical documentation supporting disease stability?  Yes  No
- Is there clinical documentation supporting disease improvement?  Yes  No

**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.