



**Sipuleucel-T (Provenge®) Injectable Medication  
Precertification Request**

**Aetna Precertification Notification**  
503 Sunport Lane, Orlando, FL 32809  
**Phone:** 1-866-503-0857  
**FAX:** 1-888-267-3277

**Please indicate:**  Start of treatment **Scheduled date of first/next infusion:** \_\_\_\_\_ **Today's date:** \_\_\_\_\_  
 Continuation of therapy **Dates of previous treatment:** \_\_\_\_\_

**Infusion Site Address:** \_\_\_\_\_

**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:
Patient Current Weight: _____ lbs or _____ kg		Patient Height: _____ inches or _____ cm	

**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: _____ (Circle 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 (Circle one): <b>Oncologist</b> <b>Urologist</b> <b>Other:</b> _____			

**D. DIAGNOSIS INFORMATION**

**Primary ICD-9:**  185 - Malignant neoplasm of prostate  
**Secondary ICD-9:** \_\_\_\_\_ **Other ICD-9 Code:** \_\_\_\_\_

**E. CLINICAL INFORMATION**

Yes  No Is the patient 18 years of age or older with histologically confirmed adenocarcinoma of the prostate with radiologic evidence of metastases to soft tissue, lymph nodes or bone?

Yes  No Has the patient been treated with surgical (bilateral orchiectomy) castration or three or more months of chemical castration (luteinizing hormone releasing hormone (LHRH) agonists or antagonists)?

Yes  No If patient was treated with chemical castration, was the serum testosterone less than 50 ng/dL at initiation of chemical castration?

Yes  No Does the patient have evidence of progressive disease after receiving surgical or chemical castration?  
If yes, please answer the following three questions:

Yes  No Has there been any change in size of the lymph nodes or parenchymal masses as noted on physical exam or radiographic studies?

Yes  No Has there been any bone scan progression evidenced by one or more new lesions or increase in size of lesions (not including "flare" that occurs at commencement of hormonal therapy or chemotherapy)?

Yes  No Has the patient had PSA progression defined by an increase in PSA over a previous reference value, where all of the following apply:

1. PSA value is measured a minimum of one week from the reference value, and
2. PSA measurement is a minimum of 25 percent greater than the reference value, and
3. An absolute-value increase in PSA of at least 5ng/ml over the reference value, and
4. This PSA increase is confirmed by a second value.

Yes  No Is the patient asymptomatic or minimally symptomatic, without cancer-related bone pain?

Yes  No Is the patient taking opioid analgesics for cancer pain?  
What is the patient's ECOG Performance Status (0 - 5): \_\_\_\_\_

Yes  No Does the patient have evidence of visceral (liver, lung or brain) metastases?

Yes  No Is the patient's life expectancy at least 6 months?

Yes  No Has the patient received any doses of Provenge previously?  
If yes, please indicate all dates of infusion(s): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**F. PRESCRIPTION INFORMATION – To be completed as a prescription order if Aetna Specialty Pharmacy is Dispensing Provider**

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Provenge – CPB 0802				

\*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.  
\*If the prescriber is providing the drug, the provider must verify benefits.

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Required by law if this Precertification Request is also used as an Aetna Specialty Pharmacy prescription order.)