



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

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)?
If patient was treated with chemical castration, please provide the serum testosterone level while on LHRH analogs _____
Date of test ____ / ____ / ____

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): ____ / ____ / ____ ____ / ____ / ____ ____ / ____ / ____