IMJUDO® (tremelimumab) Injectable Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021 (**TTY:** 711)
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: IMJUDO (tremelimumab): 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):

☐ **Esophageal, Esophagogastric Junction and Gastric Cancer**
☐ Yes ☐ No Has the patient previously received a dose of the requested medication?
☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
☐ Yes ☐ No Will the requested medication be used as neoadjuvant treatment?
☐ Yes ☐ No Will the requested medication be used in combination with durvalumab (Imfinzi)?
☐ Yes ☐ No Is the patient medically fit for surgery?

☐ **Hepatocellular carcinoma**
☐ Yes ☐ No Has the patient previously received a dose of the requested medication?
☐ Yes ☐ No Will the requested medication be used in combination with durvalumab (Imfinzi)?
Please indicate the clinical setting in which the requested medication will be used: ☐ Unresectable disease ☐ Inoperable disease ☐ Metastatic disease ☐ Extensive liver tumor burden disease ☐ Other

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

☐ **Non-small cell lung cancer (NSCLC)**

Please indicate the clinical setting in which the requested medication will be used:

☐ Advanced disease ☐ Metastatic disease ☐ Recurrent disease ☐ Other

☐ Yes ☐ No Will the requested medication be used in combination with durvalumab (Imfinzi) and platinum-based chemotherapy (e.g., cisplatin, carboplatin)?

☐ Yes ☐ No ☐ Unknown Is the tumor negative for epidermal growth factor receptor EGFR exon 19 deletion and L858R mutations and anaplastic lymphoma kinase (ALK) rearrangements?

→ ☐ Yes ☐ No Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?

How many doses of therapy has the patient received with 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.