JEMPERLI (dostarlimab-gxly) 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** ☐ **Hematologist** ☐ **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: JEMPERLI (dostarlimab-gxly) 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):

☐ Yes ☐ No Has the patient experienced disease progression while receiving another programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor (e.g., Opdivo, Keytruda)?

For Initiation Requests (clinical documentation required):

Ampullary Adenocarcinoma

☐ Yes ☐ No Will the requested drug be used as a single agent?
Please indicate the clinical setting in which the requested drug will be used: ☐ Advanced disease ☐ Recurrent disease ☐ Other
Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment
☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
☐ Yes ☐ No Has the disease progressed on or following prior treatment?
☐ Yes ☐ No Are there other satisfactory alternative treatment options available for the patient?

Breast cancer

Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent unresectable disease ☐ Stage IV disease ☐ Other
☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
☐ Yes ☐ No Has the disease progressed on or following prior treatment?
☐ Yes ☐ No Are there other satisfactory alternative treatment options available for the patient?
☐ Yes ☐ No Will the requested drug be used as a single agent?

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

Colorectal cancer, including appendiceal adenocarcinoma
Please indicate the clinical setting in which the requested drug will be used: ☐ Metastatic disease ☐ Advanced disease ☐ Other
Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment
☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
☐ Yes ☐ No Has the patient received previous oxaliplatin- irinotecan- and/or fluoropyrimidine-based (e.g., fluorouracil, capecitabine) therapy?
☐ Yes ☐ No Will the requested drug be used as a single agent?

Endometrial Carcinoma (EC)
☐ Yes ☐ No Will the requested medication be used in combination with carboplatin and paclitaxel?
→ Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Stage III-IV
☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
→ Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Advanced disease ☐ Other
☐ Yes ☐ No Has the disease progressed on or following prior treatment with a platinum-containing regimen (e.g., cisplatin, carboplatin)?

Esophageal, Esophagogastric Junction and Gastric cancer
☐ Yes ☐ No Will the requested drug be used as a single agent?
Please indicate the clinical setting in which the requested drug will be used: ☐ Unresectable locally advanced disease ☐ Recurrent disease ☐ Metastatic disease ☐ The patient is not a surgical candidate ☐ Other
☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
☐ Yes ☐ No Has the disease progressed on or following prior treatment?
☐ Yes ☐ No Are there other satisfactory alternative treatment options available for the patient?
☐ Yes ☐ No Will the requested drug be used as palliative therapy?
Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment

Occult Primary cancer
☐ Yes ☐ No Will the requested drug be used as a single agent?
☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
☐ Yes ☐ No Has the disease progressed on or following prior treatment?
☐ Yes ☐ No Are there other satisfactory alternative treatment options available for the patient?

Ovarian cancer
Please indicate which of the following applies to the patient's disease:
☐ Epithelial ovarian cancer ☐ Fallopian tube cancer ☐ Primary peritoneal cancer ☐ Carcinosarcoma (malignant mixed Mullerian tumors)
☐ Clear cell carcinoma of the ovary ☐ Mucinous carcinoma of the ovary ☐ Grade 1 endometrioid carcinoma ☐ Low-grade serous carcinoma/ ovarian borderline epithelial tumors ☐ Other
☐ Yes ☐ No Will the requested drug be used as a single agent?
Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Persistent disease ☐ Advanced disease ☐ Other
☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?

Solid tumors
Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Advanced disease ☐ Other
☐ Yes ☐ No ☐ Unknown Is the tumor mismatch repair deficient (dMMR)?
☐ Yes ☐ No Has the patient experienced disease progression following prior treatment?
☐ Yes ☐ No Are there other satisfactory alternative treatment options available for the patient?
☐ Yes ☐ No Will the requested drug be used as a single agent?

Small Bowel Adenocarcinoma
☐ Yes ☐ No Will the requested drug be used as a single agent?
Please indicate the clinical setting in which the requested drug will be used: ☐ Metastatic disease ☐ Advanced disease ☐ Other
☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?

For Continuation Requests (clinical documentation required):
☐ Yes ☐ No Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Is the patient continuing on a maintenance regimen that includes provider administered combination chemotherapy?
→ Please indicate the regimen: _____
☐ Yes ☐ No Is the patient experiencing severe toxicity requiring continuous monitoring (e.g., Grade 2-4 bullous dermatitis, transaminitis, pneumonitis, Stevens-Johnson syndrome, acute pancreatitis, primary adrenal insufficiency aseptic meningitis, encephalitis, transverse myelitis, myocarditis, pericarditis, arrhythmias, impaired ventricular function, conduction abnormalities)?
→ Please explain: _____

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☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

→ Please explain: _____

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

→ Please explain: _____

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?

→ Please explain: _____

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition:

- ☐ Cardiopulmonary: _____
- ☐ Respiratory: _____
- ☐ Renal: _____
- ☐ Other: _____

☐ Yes ☐ No Is the patient within the initial 6 months of starting therapy?

→ Please indicate how many continuous months of treatment the patient has received with the requested drug: _____

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.