Padcev™ (enfortumab vedotin-ejfv) 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:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

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 Padcev (enfortumab vedotin-ejfv) 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):

☐ **Urothelial carcinoma- bladder cancer**
☐ Yes ☐ No Will the requested drug be used for metastatic or local recurrent post-cystectomy?
☐ Yes ☐ No Will the requested drug be used for muscle invasive local recurrent or persistent disease in preserved bladder?
Please indicate the clinical setting in which the requested drug will be used: ☐ Locally advanced disease
☐ Metastatic disease
☐ Stage II disease
→ ☐ Yes ☐ No Is the tumor present following reassessment of tumor status 2-3 months after primary treatment with concurrent bladder preserving chemoradiotherapy and maximal transurethral resection of bladder tumor (TURBT)?
☐ Other

☐ **Urothelial carcinoma- primary carcinoma of the urethra**
Please indicate which clinical setting the requested drug will be used: ☐ Recurrent disease ☐ Locally advanced disease ☐ Metastatic disease ☐ Other

☐ **Urothelial carcinoma- upper genitourinary tract tumors or urothelial carcinoma of the prostate**
Please indicate the clinical setting in which the requested drug will be used: ☐ Locally advanced disease ☐ Metastatic disease ☐ Other

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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.

Please indicate the requested regimen:

☐ **Single agent**

☐ Yes ☐ No Is the patient ineligible for cisplatin-containing chemotherapy?

→ ☐ Yes ☐ No Has the patient received prior treatment with a platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?

☐ Yes ☐ No Has the patient received prior treatment with a programmed death receptor-1 (PD-1) (e.g., Keytruda, Opdivo) or programmed death-ligand (PD-L1) inhibitor (e.g., Bavencio, Tecentriq)?

Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment

☐ **In combination with pembralizumab (Keytruda)**

☐ **Other regimen**

For Continuation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is there evidence of disease progression or an unacceptable toxicity while on the current regimen?

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.