aetna®

Bavencio® (avelumab) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

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

For Medicare Advantage Part B:
FAX: 1-844-268-7263

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 ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Bavencio (avelumab): 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)

☐ Yes ☐ No Has the patient experienced disease progression following a prior anti-PD1 therapy (e.g., Opdivo (nivolumab), Keytruda (pembrolizumab), Tecentriq (atezolizumab), Bavencio (avelumab), and Imfinzi (durvalumab).)?

Bladder Urothelial Cancer:

☐ Yes ☐ No Will Bavencio (avelumab) be used as a single agent?
Please indicate clinical stage of the disease: ☐ TX-T1, NX-3, M0 ☐ T2-T4a, N 1-3, M0 ☐ T4b, NX-3, M0 ☐ Other, please identify: _____
Please select which applies to the patient's disease state:
☐ Metastatic disease
→ ☐ Yes ☐ No Will Bavencio (avelumab) be used as subsequent systemic therapy?
☐ Post cystectomy
→ ☐ Yes ☐ No Will Bavencio (avelumab) be used for recurrence?
☐ Other, please explain: _____

Merkel cell carcinoma:

Please indicate the patient's disease state: ☐ Metastatic disease ☐ Non-metastatic disease ☐ Other, Please explain: _____

Primary urothelial carcinoma of the urethra:

☐ Yes ☐ No Will Bavencio (avelumab) be given as a single agent?
Please indicate patient's disease state: ☐ Recurrent disease ☐ Metastatic disease ☐ Other - Please explain: _____
Please indicate how Bavencio (avelumab) will be used: ☐ First line therapy ☐ Subsequent systemic therapy
☐ Other - Please explain: _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION (*continued*) - Required clinical information must be completed for ALL precertification requests.

Upper genitourinary tract urothelial carcinomas:

☐ Yes ☐ No Will Bavencio (avelumab) be given as a single agent?

Please indicate patient's disease state: ☐ Recurrent disease ☐ Metastatic disease ☐ Other - Please explain: _____

Please indicate how Bavencio (avelumab) will be used: ☐ First line therapy ☐ Subsequent systemic therapy

☐ Other - Please explain: _____

Urothelial carcinoma of the prostate:

☐ Yes ☐ No Will Bavencio (avelumab) be given as a single agent?

Please indicate patient's disease state: ☐ Recurrent disease ☐ Metastatic disease ☐ Other- Please explain: _____

Please indicate how Bavencio (avelumab) will be used: ☐ First line therapy ☐ Subsequent systemic therapy

☐ Other- Please explain: _____

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

☐ Yes ☐ No Has the patient experienced disease progression while on Bavencio (avelumab)?

☐ Yes ☐ No Has the patient developed an unacceptable toxicity to Bavencio (avelumab)?

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.