Imfinzi® (durvalumab) 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 Imfinzi (durvalumab): 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 Initiation Requests: (Clinical documentation required for all requests)

☐ **Bladder cancer**
- ☐ Yes ☐ No Will Imfinzi (durvalumab) 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 Imfinzi (durvalumab) be used as subsequent systemic therapy?
  - ☐ Post cystectomy
    - → ☐ Yes ☐ No Will Imfinzi (durvalumab) be used for recurrence?
  - ☐ Other, please explain: ________

☐ **Non-small cell lung cancer**
- ☐ Yes ☐ No Will Imfinzi (durvalumab) be used as consolidation therapy?
- Please indicate the stage of the patient's disease: ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV
- Please select which of the following does the patient have: ☐ Unresectable disease ☐ Other, please identify: ________
- Please indicate the patient's performance status (PS): ☐ 0 ☐ 1 ☐ 2 ☐ 3
- ☐ Yes ☐ No Is there an evidence of disease progression after 2 or more cycles of definitive chemoradiation?

☐ **Primary carcinoma of the urethra**
- ☐ Yes ☐ No Will Imfinzi (durvalumab) be used as a single agent?
- Please indicate patient's disease state: ☐ Recurrent disease ☐ Metastatic disease ☐ Other, please identify: ________
- ☐ Yes ☐ No Will Imfinzi (durvalumab) be used as subsequent systemic therapy?

Continued on next page.

Imfinzi® (durvalumab) 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

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 genito-urinary tract tumors**
- ☐ Yes ☐ No Will Imfinzi (durvalumab) be used as a single agent?
- ☐ Yes ☐ No Does the patient have a metastatic disease?
- ☐ Yes ☐ No Will Imfinzi (durvalumab) be used as subsequent systemic therapy?

☐ **Urothelial carcinoma of prostate**
- ☐ Yes ☐ No Will Imfinzi (durvalumab) be used as a single agent?
- ☐ Yes ☐ No Does the patient have a metastatic disease?
- ☐ Yes ☐ No Will Imfinzi (durvalumab) be used as subsequent systemic therapy?

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

☐ Yes ☐ No Has the patient experienced disease progression while on Imfinzi (durvalumab)?
Please specify the type of disease progression:
☐ Locoregional metastasis ☐ Distant nodal metastasis ☐ Soft tissue metastasis ☐ Lung metastasis
☐ Visceral metastasis other than lung (i.e.: liver, brain, bone) ☐ Other – please specify: ____________________

☐ Yes ☐ No Has the patient developed an unacceptable toxicity to Imfinzi (durvalumab)?
Please specify the type of disease toxicity:
☐ Immune-mediated pneumonitis ☐ Immune-mediated colitis ☐ Immune-mediated hepatitis ☐ Infusion-related reactions
☐ Immune-mediated endocrinopathies ☐ Renal failure and Immune-mediated nephritis
☐ Other Immune-mediated adverse reactions – Please specify: ____________________
☐ Other – Please specify: ____________________

For non-small cell lung cancer (NSCLC) cancer only: Please provide the start date on Imfinzi (durvalumab) therapy: ____/____/____

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.