aetna®

Imlygic™ (talimogene laherparepvec) 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 Imlygic (talimogene laherparepvec): 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 Does the patient have a documented diagnosis of melanoma?
☐ Yes ☐ No Is this request for intralesional therapy into cutaneous, subcutaneous, or nodal melanoma lesions?
→ Please select one: ☐ Cutaneous lesions ☐ Subcutaneous lesions ☐ Nodal melanoma lesions
☐ Yes ☐ No Are the lesions visible on the skin, palpable, or detectable by ultrasound guidance?
→ Please select one: ☐ Visible on the skin ☐ Palpable ☐ Detectable by ultrasound guidance
☐ Yes ☐ No Will Imlygic (talimogene laherparepvec) be used in combination with other immune therapies (e.g., Yervoy (ipilimumab), Opdivo (nivolumab) and Keytruda (pembrolizumab)?

For Initial Requests: Please identify what Imlygic (talimogene laherparepvec) will be used to treat:

☐ **Nodal recurrence**
☐ Yes ☐ No Will Imlygic (talimogene laherparepvec) be used for unresectable or incomplete resection of nodal recurrence?
→ Please select one: ☐ Unresectable nodal recurrence ☐ Incomplete resection of nodal recurrence

☐ **Unresectable distant metastatic disease**
☐ Yes ☐ No Are extracranial lesions present?

☐ **Unresectable local, satellite and/or in-transit recurrence**
☐ Yes ☐ No Will Imlygic be used as primary or second-line treatment?
→ Please select one: ☐ Primary treatment ☐ Second-line treatment
Please select which applies to the patient's disease state: ☐ Unresectable local recurrence ☐ Unresectable satellite recurrence ☐ Unresectable in-transit recurrence ☐ Other: Please specify: _____

Continued on next page

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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.

☐ **Unresectable disease with clinical satellite or in-transit metastases**

Please select the stage of the disease: ☐ Stage 1 ☐ Stage 2 ☐ Stage 3 ☐ Stage 4

Please select which applies to the patient's disease state: ☐ Clinical satellite metastases ☐ In-transit metastases

☐ Other: Please specify: _____

☐ Yes ☐ No Will Imlygic (talimogene laherparepvec) be used as primary or second-line treatment?

→ Please select one: ☐ Primary treatment ☐ Second-line treatment

☐ Yes ☐ No Will Imlygic (talimogene laherparepvec) be used for unresectable distant metastatic disease?

☐ Yes ☐ No Are extracranial lesions present?

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

☐ Yes ☐ No Is additional other treatment now needed to treat melanoma?

→ Please indicate name and date of initiation of treatment: Name: _____ Date: ____/____/____

☐ Yes ☐ No Are there any remaining injectable lesions to treat?

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.