



# Ipilimumab (Yervoy®) Injectable Medication Precertification Request

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

**Please indicate:**  Start of treatment  Continuation of therapy **Today's date:** \_\_\_\_\_ **Date needed:** \_\_\_\_\_

**Ship to:**  Doctor's office  Patient  Other: \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Dispensing Provider:**  Aetna Specialty Pharmacy® or  Other: \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **TIN:** \_\_\_\_\_ **PIN:** \_\_\_\_\_

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

### B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

### C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Circle 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. DIAGNOSIS INFORMATION

Primary ICD-9: \_\_\_\_\_  
Secondary ICD-9: \_\_\_\_\_ Other ICD-9 Code: \_\_\_\_\_

### E. CLINICAL INFORMATION

Yes  No Does the patient have a histologically confirmed diagnosis of malignant melanoma?  
**If yes, please indicate which stage. (Check all that apply)**

- Unresectable stage III in-transit metastases
- Local, satellitosis and/or in-transit unresectable recurrence
- Incompletely resected nodal recurrence
- Limited recurrence or metastatic disease
- Disseminated recurrence or metastatic disease without brain metastases in patients with ECOG performance status 0 to 2

### F. PRESCRIPTION INFORMATION – To be completed only if Aetna Specialty Pharmacy is Dispensing Provider

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Yervoy® CPB # 0815				

\*If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.  
\*If the prescriber is providing the drug, the provider must verify benefits.  
**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)  
**Interchange is mandated unless practitioner writes the words "BRAND MEDICALLY NECESSARY" in this space:** \_\_\_\_\_