Enjaymo™ (sutimlimab-jome) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
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:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms		Allergies:	

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** ☐ **Hematologist** ☐ **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: Enjaymo (sutimlimab-jome) 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):

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?

→ Please provide a description of the behavioral issue or impairment: _____

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition:
☐ Cardiopulmonary: _____
☐ Respiratory: _____
☐ Renal: _____
☐ 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.

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

☐ Yes ☐ No Was the diagnosis of primary cold agglutinin disease (CAD) confirmed by evidence of hemolysis?

☐ Yes ☐ No Does the patient have a lactate dehydrogenase (LDH) level above the upper limit of normal?
Please indicate level: _____ U/L

☐ Yes ☐ No Does the patient have a haptoglobin level below the lower limit of normal?
Please indicate level: _____ mg/L

☐ Yes ☐ No Does the patient have a positive polyspecific direct antiglobulin test (DAT) result?

☐ Yes ☐ No Does the patient have a monospecific direct antiglobulin test (DAT) result strongly positive for C3d?

☐ Yes ☐ No Does the patient have a cold agglutinin titer of 1:64 or higher measured at 4°C?

☐ Yes ☐ No Does the patient have a DAT IgG level of 1+ or less?

☐ Yes ☐ No Has the patient had at least one blood transfusion within the last 6 months? Date of last transfusion: ____/____/____

☐ Yes ☐ No Does the patient have secondary cold agglutinin disease (CAD) (e.g., cold agglutinin syndrome secondary to infection, rheumatologic disease, or active hematologic malignancy)?

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

☐ Yes ☐ No Has patient experienced disease progression or unacceptable toxicity while on the current regimen?

☐ Yes ☐ No Is the patient responding positively to therapy (e.g., improvement in hemoglobin levels, markers of hemolysis [e.g., bilirubin, haptoglobin, lactate dehydrogenase [LDH], reticulocyte count], and a reduction in blood transfusions)?

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.