JEMPERLI (dostarlimab-gxly) 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: JEMPERLI (dostarlimab-gxly) 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 Has the patient experienced disease progression while receiving another programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor (e.g., Opdivo, Keytruda)?

For Initiation Requests (clinical documentation required):

Breast cancer
Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent unresectable disease ☐ Stage IV disease ☐ Other
☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
☐ Yes ☐ No Has the disease progressed on or following prior treatment?
☐ Yes ☐ No Are there other satisfactory alternative treatment options available for the patient?
☐ Yes ☐ No Will the requested drug be used as a single agent?

Colorectal cancer
Please indicate the clinical setting in which the requested drug will be used: ☐ Metastatic disease ☐ Advanced disease ☐ Other
Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment
☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
☐ Yes ☐ No Has the patient received previous oxaliplatin- irinotecan- and/or fluoropyrimidine-based (e.g., fluorouracil, capecitabine) therapy?
☐ Yes ☐ No Will the requested drug be used as a single agent?

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G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

Endometrial cancer (EC)

Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Advanced disease ☐ Other

☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?

☐ Yes ☐ No Has the disease progressed on or following prior treatment with a platinum-containing regimen (e.g., cisplatin, carboplatin)?

Epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer, carcinosarcoma (malignant mixed Mullerian tumors), clear cell carcinoma, mucinous carcinoma, grade 1 endometrioid carcinoma, and low-grade serous carcinoma/ ovarian borderline epithelial tumors (low malignant potential with invasive implants)

☐ Yes ☐ No Will the requested drug be used as a single agent?

Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Persistent disease ☐ Other

☐ Yes ☐ No Has the disease progressed on or following prior treatment?

☐ Yes ☐ No Are there other satisfactory alternative treatment options available for the patient?

☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?

Gastric cancer

Please indicate the clinical setting in which the requested drug will be used: ☐ Unresectable locally advanced disease ☐ Recurrent disease ☐ Metastatic disease ☐ Other

☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?

☐ Yes ☐ No Has the disease progressed on or following prior treatment?

☐ Yes ☐ No Are there other satisfactory alternative treatment options available for the patient?

☐ Yes ☐ No Will the requested drug be used as a single agent?

Please indicate the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Subsequent treatment

Occult Primary cancer

☐ Yes ☐ No Will the requested drug be used as a single agent?

☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?

Solid tumors

Please indicate the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Advanced disease ☐ Other

☐ Yes ☐ No ☐ Unknown Is the tumor mismatch repair deficient (dMMR)?

☐ Yes ☐ No Has the patient experienced disease progression following prior treatment?

☐ Yes ☐ No Are there other satisfactory alternative treatment options available for the patient?

☐ Yes ☐ No Will the requested drug be used as a single agent?

Small Bowel Adenocarcinoma, including advanced ampullary cancer

☐ Yes ☐ No Will the requested drug be used as a single agent?

Please indicate the clinical setting in which the requested drug will be used: ☐ Metastatic disease ☐ Advanced disease ☐ Other

☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Is there evidence of unacceptable toxicity or disease progression on the current regimen?

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

→ ☐ Yes ☐ No Is the patient continuing on a maintenance regimen that includes provider administered combination chemotherapy?

→ Please indicate the regimen: _____

☐ Yes ☐ No Is the patient experiencing severe toxicity requiring continuous monitoring (e.g., Grade 2-4 bullous dermatitis, transaminitis, pneumonitis, Stevens-Johnson syndrome, acute pancreatitis, primary adrenal insufficiency aseptic meningitis, encephalitis, transverse myelitis, myocarditis, pericarditis, arrhythmias, impaired ventricular function, conduction abnormalities)?

→ Please explain: _____

☐ 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?

→ Please explain: _____

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

→ Please explain: _____

☐ 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 explain: _____

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G. CLINICAL INFORMATION ***(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

☐ 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: _____

☐ Yes ☐ No Is the patient within the initial 6 months of starting therapy?

→ Please indicate how many continuous months of treatment the patient has received with the requested drug: _____

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.