



# KIMMTRAK® (tebentafusp-tebn) Injectable Medication Precertification Request

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(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: E-mail:	
Current Weight: ____ lbs or ____ kgs		Height: ____ inches or ____ cms		Allergies:	

### B. INSURANCE INFORMATION

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:		(Check one): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:		State: ZIP:
Phone:		Fax:		St Lic #: NPI #: DEA #: UPIN:	
Provider E-mail:			Office Contact Name:		Phone:
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Hematologist <input type="checkbox"/> Other: _____					

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____		<b>Dispensing Provider/Pharmacy: (Patient selected choice)</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ FAX: _____ TIN: _____ PIN: _____	
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### E. PRODUCT INFORMATION

Request is for:  KIMMTRAK (tebentafusp-tebn)  
Dose: \_\_\_\_\_ Directions for Use: \_\_\_\_\_

### F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (\*).

Primary ICD Code: \_\_\_\_\_  Other ICD Code: \_\_\_\_\_

### G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

**For Initiation Requests (clinical documentation required):**  
**Uveal melanoma**  
 Yes  No Does the patient have HLA-A\*02:01-positive mutation?  
Please indicate the clinical setting in which the requested drug will be used:  Metastatic disease  Unresectable disease  Other

**For Continuation Requests (clinical documentation required for all requests):**  
 Yes  No Is there evidence of unacceptable toxicity or disease progression while on the current regimen?

### 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.