



Padcev™ (enfortumab vedotin-ejfv) 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:			
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 #:	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 Email:			Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Other: _____						

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy: <i>Patient Selected choice</i>			
<input type="checkbox"/> Self-administered	<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Physician's Office		<input type="checkbox"/> Retail Pharmacy	
<input type="checkbox"/> Outpatient Infusion Center	Phone: _____	<input type="checkbox"/> Specialty Pharmacy		<input type="checkbox"/> Other: _____	
Center Name: _____		Name: _____			
<input type="checkbox"/> Home Infusion Center	Phone: _____	Address: _____			
Agency Name: _____		Phone: _____ Fax: _____			
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____ PIN: _____			
Address: _____					

E. PRODUCT INFORMATION

Request is for Padcev (enfortumab vedotin-ejfv) 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 Will the requested drug be used as a single agent?

Yes No Is the patient ineligible for cisplatin-containing chemotherapy?

Yes No Has the patient received prior treatment with a platinum-containing chemotherapy?

Yes No Has the patient received prior treatment with a programmed death receptor-1 (PD-1) or programmed death-ligand (PD-L1) inhibitor?

Yes No Will the requested drug be used as first-line treatment or subsequent therapy?

Please explain: First-line treatment Subsequent treatment

Urothelial carcinoma- bladder cancer

Yes No Will the requested drug be used for metastatic or local recurrent post-cystectomy?

Yes No Will the requested drug be used for muscle invasive local recurrent or persistent disease in preserved bladder?

Please indicate the clinical setting in which the requested drug will be used:

Locally advanced disease Metastatic disease Other

Stage II disease

Yes No Is the tumor present following reassessment of tumor status 2-3 months after primary treatment with bladder preserving concurrent chemoradiotherapy?

Urothelial carcinoma- primary carcinoma of the urethra

Please indicate which clinical setting the requested drug will be used: Recurrent disease Locally advanced disease Metastatic disease Other

Urothelial carcinoma- upper genitourinary tract tumors or urothelial carcinoma of the prostate

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

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

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

Yes No Is there evidence of unacceptable toxicity or disease progression 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.