Yervoy® (ipilimumab) Injectable 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:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

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

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 E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Oncologist** ☐ **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 Yervoy (ipilimumab) 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):

Please list ***all*** additional medications that will be used as part of this treatment regimen (This includes supportive care agents such as anti-emetics, growth factors, etc. A copy of the complete order may be submitted in lieu of listing out each treatment):

Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____

☐ Yes ☐ No Will the requested drug be used in combination with Zelboraf (vemurafenib), Tafinlar (dabrafenib) or Mekinist (trametinib)?
→ Please identify which medication will be used: ☐ Zelboraf (vemurafenib) ☐ Tafinlar (dabrafenib) ☐ Mekinist (trametinib)

☐ **Central nervous system (CNS) with brain metastases in patients with melanoma**
Please indicate the patient's treatment regimen: ☐ Single agent ☐ In combination with nivolumab ☐ Other

☐ **Colorectal cancer (including appendiceal carcinoma and anal adenocarcinoma)**
☐ Yes ☐ No Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
☐ Yes ☐ No Will the requested drug be used in combination with nivolumab?
Please indicate how many doses of the requested drug will be given: _____
Please select the clinical setting in which the requested drug will be used:
☐ Advanced disease ☐ Metastatic disease ☐ Unresectable disease ☐ Inoperable disease ☐ Other

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

☐ **Cutaneous melanoma**
Please select the clinical setting in which the requested drug will be used:
☐ Adjuvant treatment
→ ☐ Yes ☐ No Has the patient had a complete resection or no evidence of disease?
☐ 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: ☐ Stage III disease ☐ Stage IV disease ☐ Other
☐ Treatment of unresectable or metastatic disease
→ Please indicate the disease state: ☐ Metastatic disease ☐ Unresectable disease
☐ Yes ☐ No Has the patient had a disease progression on single-agent anti-programmed death 1 (PD-1) immunotherapy?
→ Please indicate the treatment regimen: ☐ Single agent ☐ In combination with nivolumab ☐ Other
Please indicate how many doses of the requested drug will be given: _____
→ ☐ Yes ☐ No Will the requested drug be used in combination with pembrolizumab?
☐ Other clinical setting

☐ **Hepatocellular carcinoma**
☐ Yes ☐ No Will the requested drug be used in combination with nivolumab?
Please indicate the place in therapy in which the requested drug will be used: ☐ Initial treatment ☐ Subsequent treatment
Please indicate how many doses of the requested drug will be given: _____

☐ **Malignant pleural mesothelioma**
☐ Yes ☐ No Will the requested drug be used in combination with nivolumab?

☐ **Non-Small Cell Lung Cancer**
Please indicate how the requested drug will be used:
☐ In combination with nivolumab only ☐ In combination with nivolumab and 2 cycles of platinum-doublet chemotherapy ☐ Other
Please indicate the clinical setting in which the requested drug will be used:
☐ Recurrent disease ☐ Metastatic disease ☐ Advanced disease ☐ Other
☐ Yes ☐ No ☐ Unknown Does the tumor have EGFR or ALK aberrations?
→ ☐ Yes ☐ No Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?

☐ **Renal cell carcinoma**
Please select the clinical setting in which the requested drug will be used: ☐ Relapsed disease ☐ Advanced disease ☐ Stage IV disease ☐ Other
☐ Yes ☐ No Will the requested drug be used in combination with nivolumab?
Please indicate how many doses of the requested drug will be given: _____
Please select the place in therapy in which the requested drug will be used:
☐ First-line treatment
→ Please indicate the patient's risk: ☐ Poor risk ☐ Intermediate risk
☐ Favorable risk
→ What is the histology? ☐ Clear cell ☐ Non-clear cell
☐ Subsequent treatment
→ What is the histology? ☐ Clear cell ☐ Non-clear cell

☐ **Small bowel adenocarcinoma, including advanced ampullary cancer**
☐ Yes ☐ No Will the requested drug be used in combination with nivolumab?
Please indicate the clinical setting in which the requested drug will be used: ☐ Advanced disease ☐ Metastatic disease ☐ Other
☐ Yes ☐ No Is the tumor microsatellite-instability high (MSI-H) or mismatch repair deficient (dMMR)?

☐ **Uveal Melanoma**
Please indicate the clinical setting in which the requested drug will be used: ☐ Distant metastatic disease ☐ Other
Please indicate how the requested drug will be used: ☐ Single agent ☐ In combination with nivolumab ☐ Other

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

For All Continuation Requests (clinical documentation required):

☐ Yes ☐ No Is there evidence of disease progression or unacceptable toxicity 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:

☐ Opdivo used in combination with Yervoy for non-small cell lung cancer (NSCLC)

☐ Other, Please explain: _____

☐ 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: _____

☐ 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: _____

☐ **Adjuvant treatment of melanoma only:**

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

☐ **Cutaneous melanoma** ☐ **Hepatocellular carcinoma** ☐ **Renal cell carcinoma** ☐ **Colorectal cancer only:**

Please indicate how many doses of the requested drug the patient has already received: _____

☐ **Non-small cell lung cancer** ☐ **Malignant pleural mesothelioma only:**

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.