



**TIVDAK® (tisotumab vedotin-tftv)**  
**Medication Precertification Request**

Page 1 of 1

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

Aetna Precertification Notification  
 Phone: **1-866-752-7021** (TTY: **711**)  
 FAX: **1-888-267-3277**

**For Medicare Advantage Part B:**  
 Please Use Medicare Request Form

**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 #: _____		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**

<b>Place of Administration:</b>		<b>Dispensing Provider/Pharmacy: Patient Selected choice</b>	
<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:  TIVDAK (tisotumab vedotin-tftv) 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.**

Yes  No Does the patient have a diagnosis of cervical cancer?

**For Initiation Requests (clinical documentation required):**  
 Please indicate the clinical setting in which the requested drug will be used:  Recurrent disease  Metastatic disease  Other  
 Yes  No Has the patient experienced disease progression on or after chemotherapy?  
 Yes  No Will the requested drug be used as a single agent?

**For Continuation Requests (clinical documentation required):**  
 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.