Imfinzi® (durvalumab) Injectable Medication Precertification Request

(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 #: _____
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** ☐ **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: Imfinzi (durvalumab): 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 Has the patient experienced disease progression while on PD-1 or PD-L1 inhibitor therapy (e.g., Opdivo (nivolumab)?

For Initiation Requests:

☐ **Ampullary adenocarcinoma**
Please indicate the clinical setting in which the requested medication will be used:
☐ Unresectable disease
☐ Metastatic disease
☐ Other
Please indicate the disease type: ☐ Pancreatobiliary disease ☐ Mixed type disease ☐ Other
☐ Yes ☐ No Will the requested medication be used in combination with cisplatin and gemcitabine?

☐ **Biliary tract cancer (gallbladder cancer, intrahepatic/extrahepatic cholangiocarcinoma)**
☐ Yes ☐ No Will the requested medication be used in combination with cisplatin and gemcitabine?
Please indicate the clinical setting in which the requested medication will be used:
☐ Locally advanced disease ☐ Unresectable disease ☐ Resected gross residual (R2) disease ☐ Metastatic disease ☐ Other
☐ Recurrent disease
→ ☐ Yes ☐ No Did the disease recur after surgery and adjuvant therapy?

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☐ **Cervical cancer**
- ☐ Yes ☐ No Is the requested medication being used to treat small cell neuroendocrine carcinoma of the cervix (NECC)?
- ☐ Yes ☐ No Will the requested medication be used in combination with etoposide and either cisplatin or carboplatin?
- What is the clinical setting in which the requested medication will be used? ☐ Persistent disease ☐ Metastatic disease ☐ Recurrent disease ☐ Other

☐ **Esophageal, Esophagogastric Junction and Gastric Cancer**
- ☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
- ☐ Yes ☐ No Will the requested medication be used as neoadjuvant treatment?
- ☐ Yes ☐ No Will the requested medication be used in combination with tremelimumab (Imjudo)?
- ☐ Yes ☐ No Is the patient medically fit for surgery?

☐ **Extensive-stage small cell lung cancer (ES-SCLC)**
- ☐ Yes ☐ No Will the requested medication be used in combination with etoposide and either carboplatin or cisplatin followed by single agent maintenance?
- What is the place in therapy in which the requested medication will be used? ☐ First line therapy ☐ Subsequent therapy

☐ **Hepatocellular carcinoma**
- Please indicate the requested regimen: ☐ Single agent ☐ In combination with tremelimumab-actl (Imjudo) ☐ Other
- What is the place in therapy in which the requested medication will be used? ☐ First line therapy ☐ Subsequent therapy
- Please indicate the clinical setting in which the requested medication will be used:
  - ☐ Unresectable/inoperable disease ☐ Metastatic disease ☐ Extensive liver tumor burden disease ☐ Other

☐ **Non-small cell lung cancer (NSCLC)**
- Please indicate the clinical setting in which the requested medication will be used:
  - ☐ Advanced disease
  - ☐ Metastatic disease
  - ☐ Recurrent disease
  - ☐ Unresectable Stage II or Stage III disease
    - → ☐ Yes ☐ No Has the disease progressed following concurrent platinum-based chemotherapy (e.g., cisplatin, carboplatin) and radiation therapy?
  - ☐ Other
- ☐ Yes ☐ No Will the requested medication be used in combination with tremelimumab-actl (Imjudo) and platinum-based chemotherapy (e.g., cisplatin, carboplatin)?
- ☐ Yes ☐ No ☐ Unknown Is the tumor negative for epidermal growth factor receptor (EGFR) exon 19 deletion and L858R mutation and anaplastic lymphoma kinase (ALK) rearrangements?
  - → ☐ Yes ☐ No Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?

☐ **Pleural mesothelioma**
- Please indicate the clinical setting in which the requested medication will be used: ☐ Unresectable disease ☐ Other
- What is the place in therapy in which the requested medication will be used? ☐ First line therapy ☐ Subsequent therapy
- ☐ Yes ☐ No Will the requested medication be used in combination with pemetrexed and either cisplatin or carboplatin?

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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 Has the patient experienced disease progression or unacceptable toxicity while 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 provide 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: _____
- ☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit patient's ability to tolerate a large volume or load or predispose the patient 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 medication: _____

For Esophageal, Esophagogastric Junction and Gastric Cancer: Please indicate how many doses the patient has received: ____/____/____

For Non-small cell lung cancer (NSCLC): Please provide the start date on the requested medication therapy: ____/____/____

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.