RYBREVANT® (amivantamab-vmjw) 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: ☐ **RYBREVANT (amivantamab-vmjw) 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):
☐ Yes ☐ No Does the patient have a diagnosis of non-small cell lung cancer (NSCLC)?

For Initiation Requests (clinical documentation required):
Please indicate the clinical setting in which the requested drug will be used:
☐ Recurrent disease ☐ Advanced disease ☐ Metastatic disease ☐ Other
☐ Yes ☐ No Does the patient have an epidermal growth factor receptor (EGFR) exon 20 insertion mutation?
☐ Yes ☐ No Has the disease progressed on or after platinum-based chemotherapy (e.g., cisplatin, carboplatin)?
☐ 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.