Bavencio® (avelumab) 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:		
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 #: _____
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 Bavencio (avelumab): 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 receiving another PD-1 or PD-L1 inhibitor (e.g., Opdivo (nivolumab), Keytruda (pembrolizumab), Tecentriq (atezolizumab), and Imfinzi (durvalumab))?

☐ **Bladder Urothelial Cancer**
- ☐ Yes ☐ No Will the requested drug be used as a single agent?
- ☐ Yes ☐ No Will the requested drug be used as maintenance therapy?
  - → ☐ Yes ☐ No Did the patient experience disease progression on first-line platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?

Subsequent therapy request only:
Please indicate how the requested drug will be used: ☐ First line treatment ☐ Subsequent treatment

☐ **Endometrial carcinoma**
Please select the clinical setting in which the requested drug will be used: ☐ Recurrent disease ☐ Metastatic disease ☐ Other
Please indicate how the requested drug will be used: ☐ First line treatment ☐ Second-line treatment
☐ Yes ☐ No ☐ Unknown Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
☐ Yes ☐ No Will the requested drug be used as a single agent?

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G. CLINICAL INFORMATION (*continued*) - Required clinical information must be completed for ALL precertification requests.

☐ **Gestational Trophoblastic Neoplasia**
- ☐ Yes ☐ No Will the requested drug be used as a single agent?
- ☐ Yes ☐ No Is the disease resistant to multiagent chemotherapy?

Please indicate the type of disease the patient has:
- ☐ High-risk disease
- ☐ Intermediate trophoblastic tumor (placental site trophoblastic tumor or epithelioid trophoblastic tumor)
  - → Please select the clinical setting in which the requested drug will be used:
    - ☐ Recurrent disease ☐ Progressive disease ☐ Other
    - ☐ Yes ☐ No Has the patient previously received treatment with a platinum-based (e.g., cisplatin, carboplatin) regimen?
- ☐ Other

☐ **Merkel cell carcinoma**

Please indicate the patient's disease state: ☐ Metastatic disease ☐ Other
- ☐ Yes ☐ No Will the requested drug be used as a single agent?

☐ **Primary urothelial carcinoma of the urethra**
- ☐ Yes ☐ No Will the requested drug be used as a single agent?
- ☐ Yes ☐ No Will the requested drug be used as maintenance therapy?
  - → ☐ Yes ☐ No Did the patient experience disease progression on first-line platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?

Subsequent therapy request only:

Please indicate how the requested drug will be used: ☐ First line treatment ☐ Subsequent treatment

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

☐ Recurrent disease ☐ Locally advanced disease ☐ Metastatic disease ☐ Other

☐ **Renal Cell Carcinoma**

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

☐ Advanced disease ☐ Relapsed disease ☐ Stage IV disease ☐ Other
- ☐ Yes ☐ No Does the disease have clear cell histology?

Please indicate how the requested drug will be used: ☐ First line treatment ☐ Subsequent treatment
- ☐ Yes ☐ No Will the requested drug be used in combination with axitinib (Inlyta)?

☐ **Upper genitourinary tract urothelial carcinomas**
- ☐ Yes ☐ No Will the requested drug be used as a single agent?
- ☐ Yes ☐ No Will the requested drug be used as maintenance therapy?
  - → ☐ Yes ☐ No Did the patient experience disease progression on first-line platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?

Subsequent therapy request only:

Please indicate how the requested drug will be used: ☐ First line treatment ☐ Subsequent treatment

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

☐ Locally advanced disease ☐ Metastatic disease ☐ Other

☐ **Urothelial carcinoma of the prostate**
- ☐ Yes ☐ No Will the requested drug be used as a single agent?
- ☐ Yes ☐ No Will the requested drug be used as maintenance therapy?
  - → ☐ Yes ☐ No Did the patient experience disease progression on first-line platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?

Subsequent therapy request only:

Please indicate how the requested drug will be used: ☐ First line therapy ☐ Subsequent therapy

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

☐ Locally advanced disease ☐ Metastatic disease ☐ Other

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G. CLINICAL INFORMATION (*continued*) - Required clinical information must be completed for ALL precertification requests.

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

☐ Yes ☐ No Has the patient experienced disease progression or an 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 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: _____

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.