



# Imlygic® (talimogene laherparepvec) Medication Precertification Request

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(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 #: _____	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> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	<b>Dispensing Provider/Pharmacy: Patient Selected choice</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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## E. PRODUCT INFORMATION

**Request is for Imlygic (talimogene laherparepvec) 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):**

**Melanoma**  
Please indicate which of the following applies to the patient's disease:  
 Cutaneous melanoma  Subcutaneous melanoma  Nodal lesions in melanoma  Other  
 Please indicate the clinical setting in which the requested drug will be used:  Unresectable disease  Limited resectable disease  
 Incompletely resectable disease  Other

**For Continuation Requests (clinical documentation required for all requests):**  
 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.