KIMMTRAK® (tebentafusp-tebn) 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:	E-mail:
Current Weight: ____ lbs or ____ kgs Height: ____ inches or ____ cms	Allergies:	

B. INSURANCE INFORMATION

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 E-mail:	Office Contact Name:	Phone:

Specialty *(Check one)*: ☐ **Oncologist** ☐ **Hematologist** ☐ **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: ☐ **KIMMTRAK (tebentafusp-tebn)**
Dose: __________ **Directions for Use:** __________

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (*).

Primary ICD Code: __________ ☐ **Other ICD Code**: __________

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For Initiation Requests (clinical documentation required):

Uveal melanoma

☐ Yes ☐ No Does the patient have HLA-A*02:01-positive mutation?

Please indicate the clinical setting in which the requested drug will be used: ☐ Metastatic disease ☐ Unresectable 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.