



### Imjudo® (Tremelimumab-actl) Prior Authorization Form

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

#### Drug Information

Physician billing (HCPCS code: \_\_\_\_\_) Start Date (or date of next dose): \_\_\_\_\_

Dose: \_\_\_\_\_ Regimen: \_\_\_\_\_

#### Billing Provider Information

Provider NPI: \_\_\_\_\_ Provider Name: \_\_\_\_\_

Provider Phone: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

#### Prescriber Information

Prescriber NPI: \_\_\_\_\_ Prescriber Name: \_\_\_\_\_

Prescriber Phone: \_\_\_\_\_ Prescriber Fax: \_\_\_\_\_ Specialty: \_\_\_\_\_

#### Criteria

##### For Initial Authorization:

1. Please indicate the diagnosis and information:

**Non-Small Cell Lung Cancer (NSCLC)**

A. Does the member have metastatic disease? Yes  No

B. Is there an epidermal growth factor receptor (EGFR), anaplastic lymphoma kinase (ALK), or ROS1 mutations? Yes  No

C. Will tremelimumab-actl be given in combination with durvalumab and platinum-based chemotherapy? Yes  No

**Hepatocellular Carcinoma (HCC)**

A. Is the diagnosis unresectable HCC? Yes  No

B. Will tremelimumab-actl be given in conjunction with durvalumab? Yes  No

**If diagnosis is not listed above, please indicate diagnosis:** \_\_\_\_\_

Additional Information: \_\_\_\_\_

##### For Continued Authorization:

1. Date of last dose: \_\_\_\_\_

2. Does member have any evidence of progressive disease while on tremelimumab-actl therapy?

Yes  No

3. Has the member experienced any adverse drug reactions related to tremelimumab-actl therapy?

Yes  No

A. If yes, please specify adverse reactions: \_\_\_\_\_

Additional Information: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays. Please do not send in chart notes. Specific information will be requested if necessary.*

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at [AetnaBetterHealth.com/Oklahoma](http://AetnaBetterHealth.com/Oklahoma).

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