



Jemperli® (dostarlimab-gxly) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Physician billing (HCPCS code: _____) Pharmacy billing (NDC: _____)

Dose: _____ Regimen: _____ Start Date (or date of next dose): _____

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:

Endometrial Cancer

A. Please indicate how dostarlimab-gxly will be used:

Single agent

i. Is disease advanced, recurrent, or metastatic endometrial cancer? Yes No

ii. Is disease mismatch repair deficient (dMMR)? Yes No

iii. Has disease progressed on or following prior treatment with a platinum-containing regimen?
Yes No

In combination with carboplatin and paclitaxel

i. Is disease primary advanced or recurrent endometrial cancer? Yes No

ii. Is disease mismatch repair deficient (dMMR) or microsatellite instability-high (MSI-H) disease?
Yes No

Mismatch Repair (dMMR) Solid Tumor

A. Is disease recurrent or advanced? Yes No

B. Has disease progressed on or following prior treatment? Yes No

C. Are there satisfactory treatment alternatives for the member? Yes No

If diagnosis is not listed above, please indicate diagnosis: _____

Additional Information: _____

<p>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.</p>	<p>CONFIDENTIALITY NOTICE</p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Criteria

For Continued Authorization:

1. Date of last dose: _____
2. Does patient have any evidence of progressive disease while on dostarlimab-gxly therapy? Yes No
3. Has the member experienced any adverse drug reactions related to dostarlimab-gxly therapy?
Yes No

If yes, please specify adverse reactions: _____

Additional Information: _____

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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.

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