

**Imfinzi® (Durvalumab) Prior Authorization Form**

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

**Drug Information**

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

Dose: \_\_\_\_\_ Dosing 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 (Initial approval will be for the duration of 6 months):**

1. Please indicate the diagnosis and information:

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

- A. Does member have unresectable stage II or III NSCLC? Yes \_\_\_ No \_\_\_
  - i. If yes, has member's disease progressed following concurrent platinum-based chemotherapy and radiation therapy? Yes \_\_\_ No \_\_\_
- B. Does member have metastatic NSCLC? Yes \_\_\_ No \_\_\_
  - i. If yes, does member have an epidermal growth factor (EGFR) mutation or anaplastic lymphoma kinase (ALK) genomic tumor aberrations? Yes \_\_\_ No \_\_\_
  - ii. Will durvalumab be used in conjunction with Imjudo® (tremelimumab-actl) and platinum-based chemotherapy? Yes \_\_\_ No \_\_\_

**Extensive-Stage Small Cell Lung Cancer (ES-SCLC)**

- A. Will durvalumab be used in combination with etoposide and either cisplatin or carboplatin followed by single-agent maintenance? Yes \_\_\_ No \_\_\_

**Biliary Tract Cancer**

- A. Does member have locally advanced or metastatic biliary tract cancer? Yes \_\_\_ No \_\_\_
- B. Will durvalumab be used in combination with gemcitabine and cisplatin? Yes \_\_\_ No \_\_\_

**Hepatocellular Carcinoma (HCC)**

- A. Does member have a diagnosis of unresectable HCC? Yes \_\_\_ No \_\_\_
- B. Will durvalumab be used in combination with Imjudo® (tremelimumab-actl)? 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 <a href="http://AetnaBetterHealth.com/Oklahoma">AetnaBetterHealth.com/Oklahoma</a></p>	<p><b>CONFIDENTIALITY NOTICE</b></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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**Imfinzi® (Durvalumab) Prior Authorization Form****Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_
2. Does member have any evidence of progressive disease while on durvalumab? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Has the member experienced adverse drug reactions related to durvalumab therapy?  
Yes \_\_\_\_\_ No \_\_\_\_\_

*If yes, please specify adverse reactions:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**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.*****Page 2 of 2**

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