JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Bavencio

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____kg

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____ *Route of administration* _____
Dosing frequency _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

Criteria Questions:

1. What is the diagnosis?
   - ❑ Merkel cell carcinoma
   - ❑ Urothelial carcinoma - Bladder cancer
   - ❑ Urothelial carcinoma - Primary carcinoma of the urethra
   - ❑ Urothelial carcinoma - Upper Genitourinary Tract Tumors
   - ❑ Urothelial carcinoma of the Prostate
   - ❑ Renal Cell Carcinoma
   - ❑ Gestational trophoblastic neoplasia
   - ❑ Endometrial carcinoma
   - ❑ Other, please specify _____
2. What is the ICD-10 code? _____
3. Has the patient experienced disease progression while receiving another PD-1 or PD-L1 inhibitor (e.g., Opdivo, Imfinzi)? ❑ Yes ❑ No
4. Is the patient currently receiving treatment with the requested medication?
   ❑ Yes ❑ No *If No, skip to diagnosis section*
5. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Merkel cell carcinoma

6. What is the clinical setting in which the requested drug will be used?
   - ❑ Metastatic disease
   - ❑ Other, please specify _____

Section B: Urothelial Carcinoma-Bladder Cancer

7. Will the requested drug be used as a single agent? ❑ Yes ❑ No
8. Will the requested medication be used as maintenance therapy? ❑ Yes ❑ No *If No, skip to #10*
9. Did the patient experience disease progression on first-line platinum-containing chemotherapy?
   ❑ Yes ❑ No *No further questions*
10. What is the place in therapy in which the requested drug will be used?
    ❑ First-line treatment ❑ Subsequent treatment
11. What is the clinical setting in which the requested drug will be used?
    - ❑ Locally advanced disease *No further questions*
    - ❑ Metastatic disease *No further questions*
    - ❑ Post-cystectomy
    - ❑ Preserved bladder *Skip to #13*
    - ❑ Stage II or IIIA disease *Skip to #14*
    - ❑ Other, please specify _____
12. What is the clinical setting in which the requested drug will be used following cystectomy? *No further questions*
    ❑ Metastatic disease ❑ Local recurrence ❑ Other, please specify _____
13. What is the clinical setting in which the requested drug will be used in a preserved bladder? *No further questions*
    - ❑ Muscle invasive local recurrent
    - ❑ Muscle invasive persistent disease
    - ❑ Other, please specify _____
14. Is tumor present following primary treatment? ❑ Yes ❑ No

Section C: Urothelial carcinoma – Primary carcinoma of the urethra

15. Will the drug be used as a single agent? ❑ Yes ❑ No

16. Will the requested medication be used as maintenance therapy? ❑ Yes ❑ No *If No, skip to #18*

17. Did the patient experience disease progression on first-line platinum-containing chemotherapy?
    ❑ Yes ❑ No *No further questions*

18. What is the place in therapy in which the requested drug will be used?
    ❑ First-line treatment ❑ Subsequent treatment

19. What is the clinical setting in which the requested drug will be used?
    ❑ Recurrent disease
    ❑ Locally advanced disease
    ❑ Metastatic disease
    ❑ Other, please specify _____

Section D: Urothelial carcinoma- Upper Genitourinary Tract Tumors or Urothelial Carcinoma of the Prostate

20. Will the requested drug be used as a single agent? ❑ Yes ❑ No

21. Will the requested medication be used as maintenance therapy ❑ Yes ❑ No *If No, skip to #23*

22. Did the patient experience disease progression on first-line platinum-containing chemotherapy?
    ❑ Yes ❑ No *No further questions*

23. What is the place in therapy in which the requested drug will be used?
    ❑ First-line treatment ❑ Subsequent treatment

24. What is the clinical setting in which the requested drug will be used?
    ❑ Locally advanced disease ❑ Metastatic disease ❑ Other, please specify _____

Section E: Renal Cell Carcinoma

25. What is the clinical setting in which the requested drug will be used?
    ❑ Advanced disease
    ❑ Relapsed disease
    ❑ Stage IV disease
    ❑ Other, please specify _____

26. What is the place in therapy in which the requested drug will be used?
    ❑ First-line treatment ❑ Subsequent treatment

27. Will the drug be used in combination with axitinib? ❑ Yes ❑ No

Section F: Gestational Trophoblastic Neoplasia

28. Will the requested drug be used as a single agent? ❑ Yes ❑ No

29. Is the disease resistant to multiagent chemotherapy? ❑ Yes ❑ No

30. What type of disease does the patient have?
    ❑ Intermediate trophoblastic tumor (placental site trophoblastic tumor or epithelioid trophoblastic tumor)
    ❑ High-risk disease *No further questions*
    ❑ Other, please specify _____

31. What is the clinical setting in which the requested drug will be used?
    ❑ Recurrent disease
    ❑ Progressive disease
    ❑ Other, please specify _____

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32. Has the patient previously received treatment with a platinum-based (e.g., cisplatin, carboplatin) regimen?
❑ Yes ❑ No

Section G: Endometrial Carcinoma

33. What is the clinical setting in which the requested drug will be used?
❑ Recurrent disease
❑ Metastatic disease
❑ Other, please specify _____

34. What is the place in therapy in which the requested drug will be used?
❑ First-line treatment ❑ Second-line treatment

35. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? ***ACTION REQUIRED: If 'Yes', please attach laboratory report confirming microsatellite instability-high or mismatch repair deficient tumor status.*** ❑ Yes ❑ No ❑ Unknown

36. Will the requested drug be used as a single agent? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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