Yervoy

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 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 (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

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

Criteria Questions:

What is the ICD-10 code? _____

1. Is this a request for continuation of therapy (i.e., the patient is currently being treated with the requested drug)?
❒ Yes, *Continue to 60*
❒ No, *Continue to 2*

2. What is the patient's diagnosis?

❒ Cutaneous melanoma, *Continue to 3*

❒ Uveal melanoma, *Continue to 13*

❒ Central nervous system (CNS) brain metastases in patients with melanoma, *Continue to 15*

❒ Non-small cell lung cancer, *Continue to 16*

❒ Renal cell carcinoma, *Continue to 20*

❒ Colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma), *Continue to 26*
❒ Malignant pleural or peritoneal mesothelioma (including pericardial mesothelioma and tunica vaginalis testis mesothelioma), *Continue to 30*

❒ Hepatocellular carcinoma, *Continue to 31*

❒ Small bowel adenocarcinoma, *Continue to 33*

❒ Ampullary adenocarcinoma, *Continue to 36*

❒ Esophageal and Esophagogastric Junction cancers, *Continue to 39*

❒ Kaposi sarcoma, *Continue to 43*

❒ Bone cancer, *Continue to 47*

❒ Biliary tract cancer (Cholangiocarcinoma and Gallbladder Cancer), *Continue to 52*

❒ Soft tissue sarcoma, *Continue to 56*

❒ Merkel cell carcinoma, *Continue to 58*

❒ Other, please specify. _____, *No further questions*

3. What is the clinical setting in which the requested drug will be used?

❒ Adjuvant treatment, *Continue to 4*

❒ Unresectable disease, *Continue to 9*

❒ Metastatic disease, *Continue to 9*

❒ Progressive disease, *Continue to 12*

❒ Limited resectable local recurrence, *Continue to 7*

❒ Other, please specify. _____, *No further questions*

4. What is the clinical setting in which the requested drug will be used?

❒ Stage III disease, *Continue to 5*

❒ Stage IV disease, *Continue to 5*

❒ Other, please specify. _____, *Continue to 5*

5. Is there no evidence of disease following metastasis-directed therapy (i.e., complete resection)?
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. Will the requested drug be used in any of the following regimens?

❒ Single agent, *No further questions*

❒ In combination with nivolumab (Opdivo), *No further questions*

❒ Other, please specify. _____, *No further questions*

7. Has the patient received prior treatment with anti-PD-1 therapy?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Will the requested drug be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

9. Has the patient had disease progression on single-agent anti-programmed death 1 (PD-1) immunotherapy or BRAF-targeted therapy?
❒ Yes, *Continue to 10*
❒ No, *Continue to 12*

10. What is the place in therapy in which the requested drug will be used?

❒ First-line therapy, *Continue to 11*

❒ Subsequent therapy, *Continue to 11*

11. Will the requested drug be used at a low dose in combination with pembrolizumab (Keytruda) or nivolumab (Opdivo)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

12. Will the requested drug be used in any of the following regimens?

❒ Single agent, *No further questions*
❒ In combination with nivolumab (Opdivo) (for 4 doses followed by nivolumab as a single agent), *No further questions*

❒ Other, please specify. _____, *No further questions*

13. What is the clinical setting in which the requested drug will be used?

❒ Distant metastatic disease, *Continue to 14*

❒ Other, please specify. _____, *Continue to 14*

14. Will the requested drug be used in any of the following regimens?

❒ Single agent, *No further questions*

❒ In combination with nivolumab (Opdivo), *No further questions*

❒ Other, please specify. _____, *No further questions*

15. Will the requested drug be used in any of the following regimens?

❒ Single agent, *No further questions*

❒ In combination with nivolumab (Opdivo), *No further questions*

❒ Other, please specify. _____, *No further questions*

16. Will the requested drug be used in any of the following regimens?

❒ In a regimen containing nivolumab (Opdivo), *Continue to 17*

❒ Other, please specify. _____, *Continue to 17*

17. What is the clinical setting in which the requested drug will be used?

❒ Recurrent disease, *Continue to 18*

❒ Metastatic disease, *Continue to 18*

❒ Advanced disease, *Continue to 18*

❒ Other, please specify. _____, *Continue to 18*

18. Is the patient positive for any of the following: EGFR exon 19 deletions, L858R mutations or ALK rearrangements? ***ACTION REQUIRED***: Please attach documentation of EGFR exon 19 deletions or L858R mutations and ALK rearrangements, where applicable.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ No ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Unknown, *Continue to 19*

19. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

20. What is the clinical setting in which the requested drug will be used?

❒ Relapsed disease, *Continue to 21*

❒ Advanced disease, *Continue to 21*

❒ Stage IV disease, *Continue to 21*

❒ Other, please specify. _____, *Continue to 21*

21. Will the requested drug be used in combination with nivolumab (Opdivo)?

❒ Yes, *Continue to 22*

❒ No, *Continue to 22*

22. How many doses of the requested drug will be given?

_____ doses, *Continue to 23*

23. What is the histology?

❒ Clear cell, *Continue to 24*

❒ Non-clear cell, *Continue to 24*

24. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment, *Continue to 25*

❒ Subsequent treatment, *No further questions*

25. Which of the following describes the risk?

❒ Poor risk, *No further questions*

❒ Intermediate risk, *No further questions*

❒ Favorable risk, *No further questions*

❒ Other, please specify. _____, *No further questions*

26. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming microsatellite instability-high or mismatch repair deficient tumor status.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 27*

❒ No, *Continue to 27*

❒ Unknown, *Continue to 27*

27. Will the requested drug be used in combination with nivolumab (Opdivo)?

❒ Yes, *Continue to 28*

❒ No, *Continue to 28*

28. How many doses of the requested drug will be given?

_____ doses, *Continue to 29*

29. What is the clinical setting in which the requested drug will be used?

❒ Advanced disease, *No further questions*

❒ Metastatic disease, *No further questions*

❒ Unresectable disease, *No further questions*

❒ Inoperable disease, *No further questions*

❒ Other, please specify. _____, *No further questions*

30. Will the requested drug be used in combination with nivolumab (Opdivo)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

31. Will the requested drug be used in any of the following regimens?

❒ Single agent, *Continue to 32*

❒ In combination with nivolumab (Opdivo), *Continue to 32*

❒ Other, please specify. _____, *Continue to 32*

32. How many doses of the requested drug will be given?

_____ doses, *No further questions*

33. Will the requested drug be used in combination with nivolumab (Opdivo)?
❒ Yes, *Continue to 34*
❒ No, *Continue to 34*

34. What is the clinical setting in which the requested drug will be used?

❒ Advanced disease, *Continue to 35*

❒ Metastatic disease, *Continue to 35*

❒ Other, please specify. _____, *Continue to 35*

35. Is tumor microsatellite-instability high (MSI-H) or mismatch repair deficient (dMMR)? ACTION REQURED: If Yes, attach chart note(s) or test results confirming microsatellite instability-high or mismatch repair deficient tumor status.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ No, *No further questions*

❒ Unknown, *No further questions*

36. Will the requested drug be used in combination with nivolumab (Opdivo)?
❒ Yes, *Continue to 37*
❒ No, *Continue to 37*

37. What is the clinical setting in which the requested drug will be used?

❒ Progressive disease, *Continue to 38*

❒ Unresectable disease, *Continue to 38*

❒ Metastatic disease, *Continue to 38*

❒ Other, please specify. _____, *Continue to 38*

38. Is the tumor microsatellite-instability high (MSI-H) or mismatch repair deficient (dMMR)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming microsatellite-instability high or mismatch repair deficient tumor status.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ No, *No further questions*

❒ Unknown, *No further questions*

39. What is the patient's histology?

❒ Squamous cell carcinoma, *Continue to 40*

❒ Other, please specify. _____, *Continue to 40*

40. What is the clinical setting in which the requested drug will be used?

❒ Unresectable locally advanced disease, *Continue to 41*

❒ Recurrent disease, *Continue to 41*

❒ Metastatic disease, *Continue to 41*

❒ Other, please specify. _____, *Continue to 41*

41. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment, *Continue to 42*

❒ Subsequent treatment, *Continue to 42*

42. Will the requested drug be used in combination with nivolumab (Opdivo)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

43. Which of the following type of Kaposi sarcoma applies to the patient?

❒ Classic Kaposi sarcoma, *Continue to 44*

❒ Other, please specify. _____, *Continue to 44*

44. Will the requested drug be used in combination with nivolumab (Opdivo)?
❒ Yes, *Continue to 45*
❒ No, *Continue to 45*

45. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment, *Continue to 46*

❒ Subsequent treatment, *Continue to 46*

46. What is the clinical setting in which the requested drug will be used?

❒ Relapsed/refractory disease, *No further questions*

❒ Other, please specify. _____, *No further questions*

47. Will the requested drug be used in combination with nivolumab (Opdivo)?
❒ Yes, *Continue to 48*
❒ No, *Continue to 48*

48. What is the clinical setting in which the requested drug will be used?

❒ Unresectable disease, *Continue to 49*

❒ Metastatic disease, *Continue to 49*

❒ Other, please specify. _____, *Continue to 49*

49. Is the tumor mutation burden-high (TMB-H) [greater or equal to 10 mutations/megabase (mut/Mb)] tumors?
ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming tumor mutation burden-high (TMB-H) status.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 50*

❒ No, *Continue to 50*

❒ Unknown, *Continue to 50*

50. Has the disease progressed following prior treatment?
❒ Yes, *Continue to 51*
❒ No, *Continue to 51*

51. Are there satisfactory alternative treatment options available for the patient's disease?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

52. Will the requested drug be used in combination with nivolumab (Opdivo)?
❒ Yes, *Continue to 53*
❒ No, *Continue to 53*

53. What is the place in therapy in which the requested drug will be used?
❒ First-line therapy, *Continue to 54*
❒ Subsequent therapy, *Continue to 54*

54. What is the clinical setting in which the requested drug will be used?
❒ Unresectable gross residual (R2) disease, *Continue to 55*
❒ Resected gross residual (R2) disease, *Continue to 55*
❒ Progressive disease, *Continue to 55*
❒ Metastatic disease, *Continue to 55*
❒ Other, please specify. _____, *Continue to 55*

55. Is the tumor mutation burden-high (TMB-H)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming mutation burden-high (TMB-H) status.
❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ No, *No further questions*
❒ Unknown, *No further questions*

56. Which of the following type of soft tissue sarcoma applies to the patient?
❒ Extremity/body wall sarcomas, *Continue to 57*
❒ Head/neck sarcomas, *Continue to 57*
❒ Retroperitoneal/intra-abdominal sarcomas, *Continue to 57*
❒ Rhabdomyosarcoma, *Continue to 57*
❒ Angiosarcoma, *Continue to 57*
❒ Other, please specify. _____, *Continue to 57*

57. Will the requested drug be used in combination with nivolumab (Opdivo)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

58. Will the requested drug be used in combination with nivolumab (Opdivo)?

❒ Yes, *Continue to 59*
❒ No, *Continue to 59*

59. What is the clinical setting in which the requested drug will be used?

❒ Progressive disease, *No further questions*

❒ Unresectable disease, *No further questions*

❒ Recurrent disease, *No further questions*

❒ Stage IV disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

60. What is the patient's diagnosis?

❒ Cutaneous melanoma, *Continue to 61*

❒ Uveal melanoma, *Continue to 68*

❒ Central nervous system (CNS) brain metastases in patients with melanoma, *Continue to 68*

❒ Non-small cell lung cancer, *Continue to 66*

❒ Renal cell carcinoma, *Continue to 64*

❒ Colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma), *Continue to 64*
❒ Malignant pleural mesothelioma (including pericardial mesothelioma and tunica vaginalis testis mesothelioma), *Continue to 66*

❒ Peritoneal mesothelioma, *Continue to 68*

❒ Hepatocellular carcinoma, *Continue to 64*

❒ Small bowel adenocarcinoma, *Continue to 68*

❒ Ampullary adenocarcinoma, *Continue to 68*

❒ Esophageal cancer and Esophagogastric Junction cancers, *Continue to 66*

❒ Kaposi sarcoma, *Continue to 68*

❒ Bone cancer, *Continue to 68*

❒ Biliary tract cancer (Cholangiocarcinoma and Gallbladder Cancer), *Continue to 68*

❒ Soft tissue sarcoma, *Continue to 68*

❒ Merkel cell carcinoma, *Continue to 68*

❒ Other, please specify. _____, *No further questions*

61. Is the requested drug prescribed for the adjuvant treatment of melanoma?
❒ Yes, *Continue to 62*
❒ No, *Continue to 64*

62. Is there evidence of disease progression or unacceptable toxicity on the current regimen?
❒ Yes, *Continue to 63*
❒ No, *Continue to 63*

63. How many months of adjuvant treatment has the patient received with the requested drug?

_____ months, *No further questions*

64. Is there evidence of disease progression or unacceptable toxicity on the current regimen?
❒ Yes, *Continue to 65*
❒ No, *Continue to 65*

65. How many doses of the requested drug has the patient already received?
_____ doses, *No further questions*

66. Is there evidence of disease progression or unacceptable toxicity on the current regimen?
❒ Yes, *Continue to 67*
❒ No, *Continue to 67*

67. How many continuous months of treatment has the patient received with the requested drug?
_____ months, *No further questions*

68. Is there evidence of disease progression or unacceptable toxicity on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

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

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