OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Opdualag™ (Nivolumab/Relatlimab-rmbw) 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:
   - ☐ **Unresectable or metastatic melanoma**
     a. Will Opdualag™ be used as first-line therapy? Yes ☐ No ☐
     b. Has member previously failed a PD-1 inhibitor [e.g., Keytruda® (pembrolizumab), Opdivo® (nivolumab)]? 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 nivolumab/relatlimab-rmbw therapy? Yes ☐ No ☐
3. Has the member experienced any adverse drug reactions related to nivolumab/relatlimab-rmbw therapy? Yes ☐ No ☐

If yes, please specify 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.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:
University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4