

Yervoy® (ipilimumab) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code: _____ **) Start Date (or date of next dose):** _____

Dose: _____ **Member's Weight:** _____ **(kg) Date Taken:** _____

Regimen: _____

Billing Provider Information

Provider NPI: _____ **Provider Name:** _____

Provider Phone: _____ **Provider Fax:** _____

Prescriber Information

Prescriber NPI: _____ **Prescriber Name:** _____

Prescriber Phone: _____ **Prescriber Fax:** _____ **Specialty:** _____

Criteria

Page 1 of 3 - Please complete and return all pages. Failure to complete all pages will result in processing delays.*
Please note: If Yervoy® (ipilimumab) is to be used in combination with Opdivo® (nivolumab), please completely fill out and submit the Opdivo® (nivolumab) prior authorization form (PHARM-64) that is available at: <https://oklahoma.gov/ohca/rxforms.html>

For Initial Authorization:

1. Please indicate the diagnosis and information:

Cutaneous Melanoma

Stage III cutaneous melanoma

a. Regional nodes of >1mm and no in-transit metastasis? Yes ___ No ___

b. Used as a single agent? Yes ___ No ___

As neoadjuvant therapy in combination with nivolumab as initial primary treatment for stage III cutaneous melanoma disease with clinically positive nodes? Yes ___ No ___

Unresectable or metastatic melanoma

a. Used in combination with nivolumab? Yes ___ No ___

i. Used as first-line therapy? Yes ___ No ___

ii. Used as second-line or subsequent therapy for disease progression and nivolumab not previously used? Yes ___ No ___

b. Used as a single agent? Yes ___ No ___

i. First-line therapy as a single course of 4 treatments? Yes ___ No ___

ii. Second-line or subsequent lines of therapy as single course of 4 treatments? Yes ___ No ___

iii. Retreatment, consisting of a 4-dose limit, and:

No significant systemic toxicity during prior ipilimumab therapy

Disease progressed after being stable >6 months following completion of a prior course of ipilimumab

No intervening therapy has been administered

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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

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Yervoy® (ipilimumab) Prior Authorization Form

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

Criteria

Page 2 of 3 - Please complete and return all pages. Failure to complete all pages will result in processing delays.*

For Initial Authorization (continued):

1. Please indicate the diagnosis and information (continued):

Mesothelioma

- A. Is diagnosis malignant pleural mesothelioma that cannot be surgically removed? Yes ___ No ___
- B. Will ipilimumab be used as first-line therapy? Yes ___ No ___
- C. Will ipilimumab be used in combination with nivolumab? Yes ___ No ___
 - i. Will ipilimumab be used in combination with nivolumab and 2 cycles of platinum-doublet chemotherapy? Yes ___ No ___
 - ii. Does tumor express PD-L1 $\geq 1\%$? Yes ___ No ___

Esophageal Squamous Cell Carcinoma (ESCC)

- A. Is diagnosis unresectable advanced or metastatic ESCC? Yes ___ No ___
- B. Will ipilimumab be used as first-line therapy? Yes ___ No ___
- C. Will ipilimumab be used in combination with nivolumab? Yes ___ No ___
- D. Is tumor positive for expression of PD-L1 with a combined positive score (CPS) ≥ 1 or is tumor microsatellite-instability high (MSI-H) or mismatch repair deficient (dMMR)? Yes ___ No ___
- E. Will ipilimumab be used as induction therapy and member is medically fit and planned for esophagectomy? Yes ___ No ___

Non-Small Cell Lung Cancer (NSCLC)

- A. Is diagnosis recurrent, advanced, or metastatic NSCLC? Yes ___ No ___
- B. Will ipilimumab be used for first-line therapy? Yes ___ No ___
- C. Epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations? Yes ___ No ___
- D. Will ipilimumab be used in combination with nivolumab and 2 cycles of platinum-doublet chemotherapy? Yes ___ No ___
- E. Will ipilimumab be used in combination with nivolumab and member has PD-L1 $\geq 1\%$ expression? Yes ___ No ___

Hepatocellular Carcinoma

- A. Does member have unresectable disease and is not a candidate for transplant? Yes ___ No ___
- B. Does member have metastatic disease or extensive liver tumor burden? Yes ___ No ___
- C. Will ipilimumab be used in the first-line setting? Yes ___ No ___
- D. Will ipilimumab be used as second-line or greater therapy and member has progression on or after prior therapy? Yes ___ No ___
- D. Will ipilimumab be used in combination with nivolumab? Yes ___ No ___
- E. Has the member previously failed other checkpoint inhibitors? Yes ___ No ___

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Yervoy® (ipilimumab) Prior Authorization Form**Member Name:** _____ **Date of Birth:** _____ **Member ID#:** _____**Criteria****Page 3 of 3 - Please complete and return all pages. Failure to complete all pages will result in processing delays.*****For Initial Authorization (continued):**

1. Please indicate the diagnosis and information (continued):

 Renal Cell Cancer

A. Is diagnosis relapsed or surgically unresectable stage IV disease in the initial treatment of a member with previously untreated advanced renal cell cancer? Yes ___ No ___

i. If answer to previous question is 'yes', please provide the following:

 Intermediate risk Poor risk Other: _____

B. Will ipilimumab be used in combination with nivolumab? Yes ___ No ___

C. Has the member previously failed PD-L1 or PD-1 inhibitors? Yes ___ No ___

 Colorectal Cancer

A. Is diagnosis unresectable or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer? Yes ___ No ___

B. Will ipilimumab be used in combination with nivolumab? Yes ___ No ___

 If diagnosis is not listed above, please indicate diagnosis: _____**For Continued Authorization:**

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on ipilimumab? Yes ___ No ___

3. Has the member experienced any adverse drug reactions related to ipilimumab therapy? Yes ___ No ___

If yes, please specify adverse reactions: _____**Additional Information:** _____**(Page 3 of 3)****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 PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**University of Oklahoma College of Pharmacy
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