

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

Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.
Please note: If Opdivo® (nivolumab) is to be used in combination with Yervoy® (ipilimumab), please completely fill out and submit the Yervoy® (ipilimumab) prior authorization form (PHARM-66) that is available on the OHCA website: www.okhca.org

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate the requested information:
 - A. Has the member previously failed PD-1/PD-L1 inhibitors? Yes ___ No ___
 - B. Will nivolumab be used as a single-agent? Yes ___ No ___
 - C. Will nivolumab be used in combination with ipilimumab? Yes ___ No ___
 - D. Please indicate member's ECOG performance status: _____
2. Please indicate the diagnosis and information:
 - Unresectable or Metastatic Melanoma**
 - A. Will nivolumab be used as first-line therapy for untreated melanoma? Yes ___ No ___
 - B. Will nivolumab be used as second-line or subsequent therapy for documented disease progression while receiving or since completing most recent therapy? Yes ___ No ___
 - C. If using in combination with ipilimumab, please provide member's weight (kg): _____
 - Adjuvant treatment of melanoma**
 - A. Has member had complete resection of melanoma? Yes ___ No ___
 - B. Is diagnosis stage IIIB/C melanoma following complete resection? Yes ___ No ___
 - Hodgkin Lymphoma**
 - A. Is diagnosis relapsed or refractory classical Hodgkin lymphoma? Yes ___ No ___
 - B. Is diagnosis lymphocyte-predominant Hodgkin lymphoma? Yes ___ No ___
 - Recurrent or Metastatic Head and Neck Cancer**
 - A. Histology: Squamous Cell Other: _____
 - B. Has member previously received platinum-containing chemotherapy (cisplatin or carboplatin)? Yes ___ No ___
 - Esophageal Squamous Cell Carcinoma (ESCC)**
 - A. Is diagnosis unresectable advanced, recurrent, or metastatic disease? Yes ___ No ___
 - B. Will nivolumab be used following prior fluoropyrimidine- and platinum-based chemotherapy? Yes ___ No ___
 - Gastric Cancer, Gastroesophageal Junction (GEJ) Cancer, and Esophageal Adenocarcinoma**
 - A. Is diagnosis advanced, or metastatic disease? Yes ___ No ___
 - B. Will nivolumab be used in combination with fluoropyrimidine- and platinum- containing chemotherapy [e.g., folinic acid, fluorouracil, and oxaliplatin (FOLFOX) or capecitabine and oxaliplatin (CapeOX)]? Yes ___ No ___
 - Small Cell Lung Cancer**
 - A. Did disease relapse within 6 months of initial chemotherapy? Yes ___ No ___
 - B. Is disease progressive on initial chemotherapy? Yes ___ No ___
 - Mesothelioma**
 - A. Is diagnosis malignant pleural mesothelioma that cannot be surgically removed? Yes ___ No ___
 - B. Will nivolumab be used as first-line therapy? Yes ___ No ___

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

Criteria

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

2. Please indicate the diagnosis and information, continued:

Non-Small Cell Lung Cancer (NSCLC)

A. For **first-line** therapy:

- i. Is diagnosis recurrent, advanced, or metastatic disease? Yes ___ No ___
- ii. Epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations? Yes ___ No ___
- iii. Does tumor express PD-L1 $\geq 1\%$? Yes ___ No ___
- iv. Will nivolumab be given in combination with 2 cycles of platinum-doublet chemotherapy? Yes ___ No ___

B. For **second-line** therapy:

- i. Is diagnosis metastatic disease? Yes ___ No ___
- ii. Tumor histology: Adenocarcinoma Squamous Cell Large Cell Other: _____
- iii. Will nivolumab be used following disease progression on or after platinum-containing chemotherapy (cisplatin or carboplatin)? 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 ___
 - i. Will nivolumab be used as first-line therapy? Yes ___ No ___
 - a. Is member ineligible for tyrosine kinase inhibitors or anti-angiogenic agents? Yes ___ No ___
 - ii. Will nivolumab be used as second-line or greater therapy? Yes ___ No ___
 - a. Has member failed other checkpoint inhibitors? Yes ___ No ___

Renal Cell Cancer monotherapy

- A. Is diagnosis relapsed or surgically unresectable stage IV disease? Yes ___ No ___
- B. Has member previously failed sunitinib, sorafenib, pazopanib, or axitinib? Yes ___ No ___

Renal Cell Cancer for use in combination with ipilimumab or cabozantinib

- 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. Please provide member's weight (kg): _____

Urothelial Bladder Cancer

- A. Is diagnosis metastatic or unresectable locally advanced cancer? Yes ___ No ___
- B. Is nivolumab being used as second-line or greater therapy? Yes ___ No ___
- C. Has member previously failed a platinum-containing regimen? Yes ___ No ___

Colorectal Cancer

- A. Is diagnosis Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR) metastatic colorectal cancer? Yes ___ No ___
- B. Has cancer progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan? Yes ___ No ___

If answer is none of the above, please indicate diagnosis: _____

For Continued Authorization:

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

If yes, please specify adverse 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. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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