OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
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:_____ 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 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 on the OHCA website: www.okhca.org

For Initial Authorization (Initial approval will be for the duration of 6 months):
1. Please indicate the diagnosis and information:

- ❑ **Unresectable or Metastatic Melanoma**
  - A. Will ipilimumab be used in combination with nivolumab as first-line therapy? Yes☐ No☐
  - B. Will ipilimumab be used in combination with nivolumab as second-line or subsequent therapy for disease progression if nivolumab was not previously used? Yes☐ No☐
    - i. If answer to previous question is 'yes', please provide the following:
      - a. Has the member previously failed PD-1/PD-L1 inhibitors? Yes☐ No☐
  - C. Will ipilimumab be used as a single-agent for first-line therapy? Yes☐ No☐
  - D. Will ipilimumab be used as a single-agent for second-line or subsequent lines of therapy? Yes☐ No☐
  - E. Will ipilimumab be used as a single-agent for retreatment? Yes☐ No☐
    - i. If answer to previous question is 'yes', please provide the following:
      - a. Did member experience significant systemic toxicity during prior ipilimumab therapy? Yes☐ No☐
      - b. Did disease progress after being stable for greater than six months following completion of a prior course of ipilimumab, and for whom no intervening therapy has been administered? Yes☐ No☐
  - F. Please provide member's weight (kg):_____
  - G. Please indicate member's ECOG performance status (0-5):_____
- ❑ **Adjuvant Treatment of Melanoma**
  - A. Has member had complete resection of melanoma with lymphadenectomy? Yes☐ No☐
  - B. Does member have Stage III disease with regional nodes of >1 mm and no in-transit metastasis? Yes☐ No☐
  - C. Will ipilimumab be used as a single-agent? Yes☐ No☐
  - D. Please provide member's weight (kg):_____
- ❑ **Small Cell Lung Cancer**
  - A. Did disease relapse within 6 months of initial chemotherapy? Yes☐ No☐
  - B. Did disease progress on initial chemotherapy? Yes☐ No☐
  - C. Will ipilimumab be used in combination with nivolumab? Yes☐ No☐
  - D. Please indicate member's ECOG performance status (0-5)_____

Please complete and return all pages. Failure to complete all pages will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*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.*

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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.

For Initial Authorization (continued)

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

❑ **Non-Small Cell Lung Cancer (NSCLC)**
- A. Is diagnosis recurrent, advanced, or metastatic disease? Yes☐ No☐
- B. Will ipilimumab be used as first-line therapy in metastatic disease? Yes☐ No☐
- C. Epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations? Yes☐ No☐
- D. Will ipilimumab be given in combination with nivolumab? Yes☐ No☐
- E. Does tumor express PD-L1 ≥1%? Yes☐ No☐
- F. Will ipilimumab be given in combination with 2 cycles of platinum-doublet chemotherapy? Yes☐ No☐

❑ **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☐
- D. Please provide member's weight (kg):_____

❑ **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☐
- C. Will ipilimumab be used in combination with nivolumab? 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 as second-line or greater 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☐

❑ **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☐

❑ **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 ipilimumab? Yes☐ No☐
3. Has the member experienced adverse drug reactions related to ipilimumab therapy? Yes☐ No☐
   *If yes, please specify adverse reactions:*_____

Please complete and return all pages. Failure to complete all pages will result in processing delays.

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.*

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