PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Opdivo (Nivolumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address: Address:	
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Please provide ICD code(s) for diagnosis.

Q2. For which diagnosis is Opdivo (Nivolumab) being prescribed?

- ☐ Unresectable or metastatic melanoma
- ☐ Metastatic, progressive non-small cell lung cancer (NSCLC)
- ☐ Recurrent or metastatic squamous cell carcinoma of the head and neck
- ☐ Classical Hodgkin lymphoma
- ☐ Advanced renal cell carcinoma
- ☐ Locally advanced or metastatic urothelial carcinoma
- ☐ Other (please specify)

Q3. If you selected "other" in question 2, please provide documentation that use is consistent with a category 2A or higher recommendation per NCCN compendia or guidelines.

Q4. Please indicate location of administration.

- ☐ Home
- ☐ Long Term Care (LTC) facility

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☐ Physician office (drug from office stock - buy and bill)
☐ Physician office (drug from pharmacy with a prescription)

Q5. Is the prescriber an Oncologist or Hematologist?
☐ Yes ☐ No

Q6. If using for NSCLC and tumor has EGFR or ALK genomic tumor aberrations, has patient had disease progression on approved EGFR or ALK directed therapy?
☐ Yes
☐ No
☐ N/A - Member does not have EGFR or ALK genomic tumor aberrations

Q7. If using Opdivo for NSCLC, squamous cell carcinoma of the head and neck, or urothelial cancer, did the patient have disease progression on or after platinum-containing chemotherapy?
☐ Yes ☐ No

Q8. If using Opdivo for advanced renal cell carcinoma, has patient received prior anti-angiogenic therapy?
☐ Yes ☐ No

Q9. If using for unresectable or metastatic melanoma, please select how Opdivo will be used from the options below.
☐ Opdivo will be used as a single agent for treatment of BRAF V600 wild-type or BRAF V600 mutation-positive disease
☐ Opdivo will be used in combination with ipilimumab (Yervoy)
☐ Other (Please Specify)

Q10. If using Opdivo for classical Hodgkin Lymphoma, has patient relapsed or progressed following autologous hematopoietic stem cell transplant (HSCT) and post-transplant brentuximab vedotin (Adcetris)
☐ Yes ☐ No

Q11. Will the patient be using systemic corticosteroids and / or immunosuppressants while taking Opdivo?
☐ Yes ☐ No

Q12. Does the patient have a history of severe immune-mediated adverse reaction from treatment with ipilimumab, requiring use of corticosteroids for 12 weeks for more?
☐ Yes ☐ No

Q13. Additional Comments

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_____ _____

Prescriber Signature Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.