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)
- ☐ Advanced renal cell carcinoma
- ☐ Classical Hodgkin lymphoma
- ☐ Recurrent or metastatic squamous cell carcinoma of the head and neck
- ☐ Locally advanced or metastatic urothelial carcinoma
- ☐ Metastatic colorectal cancer
- ☐ Other (please specify)

Q3. If you selected "other" in question 2, please provide documentation that use is consistent with a category 1 recommendation per NCCN compendia or guidelines.

Q4. Is the prescriber an Oncologist or Hematologist?

☐ Yes ☐ No

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Q5. If using Opdivo 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)

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 Opdivo for classical Hodgkin Lymphoma, has patient relapsed or progressed following one of the following?

- ☐ Autologous hematopoietic stem cell transplant (HSCT) and post-transplant brentuximab vedotin (Adcetris)
- ☐ 3 or more lines of systemic therapy including autologous HSCT
- ☐ Other (please specify)
- ☐ None of the above

Q10. If using Opdivo for metastatic colorectal cancer, does the patient have microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) with progression following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan?

☐ 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?

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☐ Yes	☐ No

Q13. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility
- ☐ Other (please specify)

Q14. Provide name and NPI of the billing entity

Q15. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical	☐ Pharmacy

Q16. Additional Comments

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 a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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