



Opdivo

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copy or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ cm

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Opdivo SGM – 04/2022.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

Criteria Questions:

1. What is the diagnosis?
 - Cutaneous melanoma
 - Non-small cell lung cancer (NSCLC)
 - Renal cell carcinoma
 - Classical Hodgkin lymphoma (cHL)
 - Cervical cancer
 - Squamous cell carcinoma of the head and neck (SCCHN)
 - Nasopharyngeal Carcinoma (NPC)
 - Urothelial carcinoma - Bladder cancer
 - Urothelial carcinoma - Primary carcinoma of the urethra
 - Urothelial carcinoma - Upper genitourinary tract tumor or urothelial carcinoma of the prostate
 - Colorectal cancer (including appendiceal carcinoma and anal adenocarcinoma)
 - Small bowel adenocarcinoma (including advanced ampullary cancer)
 - Hepatocellular carcinoma
 - Uveal melanoma
 - Anal carcinoma
 - Merkel cell carcinoma
 - Central nervous system (CNS) brain metastases in patients with melanoma or non-small cell lung cancer
 - Gestational trophoblastic neoplasia
 - Malignant pleural mesothelioma
 - Esophageal and esophagogastric junction carcinoma
 - Extranodal NK/T-cell lymphoma, nasal type
 - Endometrial carcinoma
 - Vulvar squamous cell carcinoma
 - Gastric cancer
 - Small cell lung cancer
 - Other _____

2. What is the ICD-10 code? _____

3. Will the requested drug be used in any of the following regimens?
 - Single agent
 - In combination with ipilimumab and pemetrexed plus carboplatin or cisplatin
 - In combination with ipilimumab, paclitaxel, and carboplatin
 - In combination with ipilimumab only
 - In combination with brentuximab vedotin
 - In combination with cabozantinib
 - In combination with chemotherapy
 - In combination with cisplatin and gemcitabine
 - In a regimen containing ipilimumab
 - In combination with platinum-doublet chemotherapy (e.g., docetaxel and cisplatin)
 - Other _____

4. Has the patient experienced disease progression while receiving another programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor (e.g., Keytruda, Imfinzi)? Yes No *If No, skip to #7*

5. Is the requested drug prescribed as second-line or subsequent treatment for metastatic or unresectable melanoma?
 Yes No

6. Will the requested drug be used in combination with ipilimumab following disease progression on single agent anti-PD-1 immunotherapy? Yes No

7. What is the clinical setting in which the requested drug will be used? **Indicate ALL that apply.**

<input type="checkbox"/> Recurrent disease	<input type="checkbox"/> Relapsed disease	<input type="checkbox"/> Refractory disease
<input type="checkbox"/> Advanced disease	<input type="checkbox"/> Metastatic disease	<input type="checkbox"/> Distant metastatic disease
<input type="checkbox"/> Progressed disease	<input type="checkbox"/> Stage II or IIIA disease	<input type="checkbox"/> High-Risk disease

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Opdivo SGM – 04/2022.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

- Unresectable disease
- Progressive disease
- Stage IV disease
- Post-cystectomy
- Very advanced disease
- Postoperative therapy for completely resected disease
- High risk of recurrence after undergoing radical resection
- Other _____
- Favorable risk
- Locally advanced disease
- Recurrent disseminated disease
- Unresectable locally advanced disease
- Patient is not a surgical candidate
- Local recurrence
- Adjuvant treatment
- Preserved bladder
- Inoperable disease
- Resectable disease

8. What is the place in therapy in which the requested drug will be used?
 Initial treatment First-line treatment Subsequent treatment Second-line treatment
 Other _____
9. Is the patient currently receiving treatment with the requested medication? Yes No *If Yes, skip to Section Q.*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Cutaneous Melanoma

10. *If adjuvant treatment*, what is the clinical setting in which the requested drug will be used?
 Stage III disease Stage IV disease Other _____
11. *If adjuvant treatment*, has the patient had a complete resection or no evidence of disease? Yes No

Section B: Non-small cell lung cancer

12. Are there no EGFR exon 19 deletions or L858R mutations or ALK rearrangements? **ACTION REQUIRED: Please attach documentation of EGFR exon 19 deletions or L858R mutations or ALK rearrangements, where applicable.** *If Yes or No, no further questions* Yes No Unknown
13. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue? Yes No
14. If in combination with platinum-doublet chemotherapy, will the requested drug be used as neoadjuvant treatment?
 Yes No

Section C: Renal cell carcinoma

15. Which of the following describes the risk?
 Poor risk Intermediate risk Favorable risk Other _____
16. What is the histology? Clear cell Non-clear cell

Section D: Classical Hodgkin Lymphoma

17. Has the patient received 2 or more prior lines of therapy? *If Yes, no further questions* Yes No
18. Has the patient received a hematopoietic stem cell transplant? *If Yes, no further questions* Yes No
19. Is the patient eligible for transplant? Yes No *If No, no further questions*
20. Has the patient been heavily pretreated? *If Yes, no further questions* Yes No
21. Did the patient experience a decrease in cardiac function? Yes No

Section E: Cervical Cancer

22. Is the patient's disease positive for programmed death ligand 1 (PD-L1) (combined positive score [CPS] ≥1)?
Action Required: If 'Yes', attach supporting chart note(s) for PD-L1 expression. Yes No

Section F: Squamous Cell Carcinoma of the Head and Neck

23. Has the patient experienced disease progression on or after platinum-containing chemotherapy (e.g., cisplatin, carboplatin)? Yes No

Section G: Bladder Cancer

24. *If the patient has high risk of recurrence after undergoing radical resection*, will the requested drug be used as adjuvant treatment? Yes No *No further questions*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Opdivo SGM – 04/2022.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062
 Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com**

25. *If the patient has a preserved bladder*, what is the clinical setting in which the requested drug will be used in a preserved bladder?
 Muscle invasive local recurrence
 Muscle invasive persistent disease
 Other _____
26. *If the clinical setting is Stage II or IIIA disease*, is the tumor present following primary bladder preserving chemoradiation? Yes No

Section H: Primary Carcinoma of the Urethra and Upper genitourinary tract tumor or urethelial carcinoma of the prostate

27. *If the patient has high risk of recurrence after undergoing radical resection*, will the requested drug be used as adjuvant treatment? Yes No *No further questions*

Section I: Colorectal Cancer

28. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
ACTION REQUIRED: If Yes, attach laboratory report confirming microsatellite instability-high or mismatch repair deficient tumor status. Yes No Unknown

Section J: Merkel Cell Carcinoma

29. Will the requested drug be used as neoadjuvant treatment? Yes No

Section K: Central nervous system (CNS) brain metastases in patients with melanoma or non-small cell lung cancer

30. What type of underlying cancer does the patient have?
 Melanoma *If Melanoma, no further questions* Non-small cell lung cancer Other
31. Is the patient's disease positive for programmed death ligand 1 (PD-L1)? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s) for PD-L1 expression.*** Yes No Unknown

Section L: Gestational Trophoblastic Neoplasia

32. Is the disease resistant to multi-agent chemotherapy? Yes No
33. What type of disease does the patient have?
 Intermediate trophoblastic tumor (placental site trophoblastic tumor or epithelioid trophoblastic tumor)
 High-risk disease *No further questions*
 Other _____
34. Has the patient previously received treatment with a platinum/etoposide-containing regimen?
 Yes No

Section M: Esophageal and esophagogastric junction carcinoma

35. Will the requested medication be used as postoperative therapy following preoperative chemoradiation and complete tumor resection? *If Yes, skip to #37* Yes No
36. What is the patient's histology?
 Squamous cell carcinoma, *no further questions* Adenocarcinoma, *no further questions*
37. Does the patient have residual pathologic disease? Yes No

Section N: Small bowel adenocarcinoma, including advanced ampullary cancer

38. Is the tumor microsatellite-instability high (MSI-H) or mismatch repair deficient (dMMR)?
ACTION REQUIRED: If 'Yes', attach laboratory report confirming microsatellite instability-high or mismatch repair deficient tumor status. Yes No Unknown

Section O: Endometrial Carcinoma

39. Is the tumor mismatch repair deficient (dMMR)? ***ACTION REQUIRED: If 'yes', attach laboratory report confirming mismatch repair deficient tumor status.*** Yes No Unknown

Section P: Vulvar Squamous Cell Carcinoma

40. Is the disease HPV-related? Yes No

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Opdivo SGM – 04/2022.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062
 Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

Section Q: Continuation of Therapy

41. Is there evidence of disease progression or unacceptable toxicity on the current regimen? Yes No
42. *For adjuvant Treatment of Melanoma or Urothelial Carcinoma*, is the requested drug prescribed for the adjuvant treatment of melanoma or urothelial carcinoma? Yes No
43. *For Non-small cell lung cancer*, is this request for neoadjuvant treatment of NSCLC?
 Yes No *If No skip to #46*
44. *For neoadjuvant treatment of NSCLC*, how many months has the patient received therapy with the requested medication? _____ months *No further questions*
45. *For Renal Cell Carcinoma*, how many continuous months of treatment has the patient received with the requested drug in combination with cabozantinib? _____ months
46. *For all indications except Renal cell Carcinoma*, how many continuous months of treatment has the patient received with the requested drug? _____ months

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Opdivo SGM – 04/2022.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com