Opdivo

Prior Authorization Request

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

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 **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay 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* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Criteria Questions:

1. What is the diagnosis?
   - ❑ Metastatic non-small cell lung cancer (NSCLC)
   - ❑ Advanced, relapsed or unresectable renal cell carcinoma (RCC)
   - ❑ Unresectable or metastatic melanoma
   - ❑ Adjuvant treatment of melanoma
   - ❑ Recurrent or metastatic squamous cell carcinoma of the head and neck
   - ❑ Classical Hodgkin lymphoma (cHL)
   - ❑ Locally advanced or metastatic urothelial carcinoma
   - ❑ Small cell lung cancer
   - ❑ Unresectable locally advanced or metastatic colorectal cancer (includes appendix and small bowel cancer)
   - ❑ Hepatocellular carcinoma
   - ❑ Malignant Pleural Mesothelioma
   - ❑ Other _____
2. What is the ICD-10 code? _____

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

Section A: Non-Small Cell Lung Cancer

3. For which of the following is Opdivo being requested?
   - ❑ For disease progression on a first-line cytotoxic regimen
   - ❑ For further progression on other systemic therapy
   - ❑ None of the above

Section B: Adjuvant Treatment of Melanoma

4. Was the disease metastatic or involving the lymph nodes? ❑ Yes ❑ No
5. Has the melanoma been fully resected? ❑ Yes ❑ No

Section C: Squamous Cell Carcinoma of the Head and Neck

6. Has the patient experienced disease progression on or after platinum-based therapy? ❑ Yes ❑ No

Section D: Urothelial Carcinoma

7. Has the patient experienced disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy? *If Yes, no further questions* ❑ Yes ❑ No
8. Has the patient experienced disease progression during or following platinum-containing chemotherapy? ❑ Yes ❑ No

Section E: Colorectal Cancer

9. Does the disease express high microsatellite instability or defective mismatch repair? ❑ Yes ❑ No

Section F: Hepatocellular Carcinoma

10. Has the patient been previously been treated with sorafenib? ❑ Yes ❑ No

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)**