# Yervoy

## 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 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* ❑ *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**

**Criteria Questions:**

1. What is the patient's diagnosis?
   - ❑ Cutaneous melanoma
   - ❑ Uveal melanoma
   - ❑ Central nervous system (CNS) brain metastases in patients with melanoma
   - ❑ Non-small cell lung cancer
   - ❑ Renal cell carcinoma
   - ❑ Colorectal cancer (including appendiceal carcinoma and anal adenocarcinoma)
   - ❑ Malignant pleural mesothelioma
   - ❑ Hepatocellular carcinoma
   - ❑ Small bowel adenocarcinoma, including advanced ampullary cancer
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Is this a request for continuation of therapy (i.e., the patient is currently being treated with the requested drug)? *If Yes, skip to Section F.* ❑ Yes ❑ No

4. How many doses of the requested drug will be given? _____ doses

5. Will the requested drug be used in any of the following regimens?
   - ❑ Single agent
   - ❑ In combination with nivolumab
   - ❑ In combination with nivolumab and 2 cycles of platinum-doublet chemotherapy
   - ❑ In combination with pembrolizumab
   - ❑ In combination with nivolumab only
   - ❑ In combination with nivolumab and 2 cycles of platinum-doublet chemotherapy
   - ❑ Other _____

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

| | | |
|---|---|---|
| ❑ Adjuvant treatment | ❑ Unresectable disease | ❑ Distant metastatic disease |
| ❑ Advanced disease | ❑ Primary progressive disease | ❑ Relapsed disease |
| ❑ Stage IV disease | ❑ Unresectable metachronous metastases | ❑ Recurrent disease |
| ❑ Metastatic disease | ❑ Other _____ | |

7. What is the place in therapy in which the requested drug will be used?
   ❑ Initial treatment ❑ First-line treatment ❑ Primary treatment ❑ Subsequent treatment
   ❑ Other _____

***Complete the following section based on the patient's diagnosis and/or Section F: Continuation of Therapy section, if applicable.***

Section A: Cutaneous Melanoma

8. What is the clinical setting in which the requested drug will be used?
   ❑ Stage III disease ❑ Stage IV disease ❑ Other _____

9. Has the patient had a complete resection or no evidence of disease? ❑ Yes ❑ No

10. Has the patient had disease progression on single-agent anti-programmed death 1 (PD-1) immunotherapy?
    ❑ Yes ❑ No

Section B: Non-Small Cell Lung Cancer

11. Does the tumor have EGFR or ALK aberrations? ***ACTION REQUIRED: Please attach documentation of EGFR and ALK aberrations if applicable***. ❑ Yes ❑ No ❑ Unknown *If Yes or No, no further questions.*

12. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue? ❑ Yes ❑ No

Section C: Renal Cell Carcinoma

13. Which of the following describes the risk?
    ❑ Poor risk ❑ Intermediate risk ❑ Favorable risk ❑ Other _____

14. What is the histology? ❑ Clear cell ❑ Non-clear cell

Section D: Colorectal Cancer

15. 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

Section E: Small Bowel Adenocarcinoma, Including Advanced Ampullary Cancer

16. 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

Section F: Continuation of Therapy

17. Is there evidence of disease progression or unacceptable toxicity on the current regimen? ❑ Yes ❑ No

*Adjuvant Treatment of Melanoma*

18. Is the requested drug prescribed for the adjuvant treatment of melanoma? ❑ Yes ❑ No

19. How many months of adjuvant treatment has the patient received with the requested drug? _____ months

*Cutaneous Melanoma, Renal Cell Carcinoma Colorectal Cancer, Hepatocellular Carcinoma*

20. How many doses of the requested drug has the patient already received? _____ doses

Non-Small Cell Lung Cancer or Malignant Pleural Mesothelioma

21. How many continuous months of treatment has the patient received with the requested drug? _____ doses

***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)**

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