OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Opdivo® (Nivolumab) Prior Authorization Form

***Member Name:*_____ *Date of Birth:*_____ *Member ID#:*_____**

Drug Information

Physician billing (HCPCS code:_____) *Start Date (or date of next dose):*_____
***Dose:*_____ *Regimen:*_____**

Billing Provider Information

***Provider NPI:*_____ *Provider Name:*_____**

***Provider Phone:*_____ *Provider Fax:* _____**

Prescriber Information

***Prescriber NPI:*_____ *Prescriber Name:*_____**

***Prescriber Phone:*_____ *Prescriber Fax:*_____*Specialty:*_____**

Criteria

Page 1 of 2—Please complete and return all pages. *Failure to complete all pages will result in processing delays.
Please note: If Opdivo® (nivolumab) is to be used in combination with Yervoy® (ipilimumab), please completely fill out and submit the Yervoy® (ipilimumab) prior authorization form (PHARM-66) that is available on the OHCA website: www.okhca.org

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate the requested information:
   - A. Has the member previously failed PD-1/PD-L1 inhibitors? Yes ☐ No ☐
   - B. Will nivolumab be used as a single-agent? Yes ☐ No ☐
   - C. Will nivolumab be used in combination with ipilimumab? Yes ☐ No ☐
2. Please indicate the diagnosis and information:

☐ **Unresectable or Metastatic Melanoma**
- A. Will nivolumab be used as first-line therapy for untreated melanoma? Yes ☐ No ☐
- B. Will nivolumab be used as second-line or subsequent therapy for documented disease progression while receiving or since completing most recent therapy? Yes ☐ No ☐
- C. If using for second-line or subsequent therapy, please indicate member's ECOG performance status:_____
- D. If using in combination with ipilimumab, please provide member's weight (kg):_____

☐ **Adjuvant treatment of melanoma**
- A. Has member had complete resection of melanoma? Yes ☐ No ☐
- B. Is diagnosis stage IIIB/C melanoma following complete resection ? Yes ☐ No ☐

☐ **Hodgkin Lymphoma**
- A. Is diagnosis relapsed or refractory classical Hodgkin lymphoma? Yes ☐ No ☐
- B. Is diagnosis lymphocyte-predominant Hodgkin lymphoma? Yes ☐ No ☐

☐ **Non-Small Cell Lung Cancer (NSCLC)**
- A. For **first-line** therapy:
  - i. Is diagnosis recurrent, advanced, or metastatic disease? Yes ☐ No ☐
  - ii. Epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations? Yes ☐ No ☐
  - iii. Does tumor express PD-L1 ≥1%? Yes ☐ No ☐
  - iv. Will nivolumab be given in combination with 2 cycles of platinum-doublet chemotherapy? Yes ☐ No ☐
- B. For **second-line** therapy:
  - i. Is diagnosis metastatic disease? Yes ☐ No ☐
  - ii. Tumor histology: ☐Adenocarcinoma ☐Squamous Cell ☐Large Cell ☐Other:_____
  - iii. Will nivolumab be used following disease progression on or after platinum-containing chemotherapy (cisplatin or carboplatin)? Yes ☐ No ☐
  - iv. Please indicate member's ECOG performance status:_____

☐ **Small Cell Lung Cancer**
- A. Did disease relapse within 6 months of initial chemotherapy? Yes ☐ No ☐
- B. Is disease progressive on initial chemotherapy? Yes ☐ No ☐
- C. Please indicate member's ECOG performance status:_____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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Member Name:_____ Date of Birth:_____ Member ID#:_____

Criteria

Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

2. Please indicate the diagnosis and information, continued:

☐ **Renal Cell Cancer monotherapy**
- A. Is diagnosis relapsed or surgically unresectable stage IV disease? Yes ☐ No ☐
- B. Has member previously failed sunitinib, sorafenib, pazopanib, or axitinib? Yes ☐ No ☐
- C. Please indicate member's ECOG performance status:_____

☐ **Renal Cell Cancer for use in combination with ipilumumab**
- A. Is diagnosis relapsed or surgically unresectable stage IV disease in the initial treatment of a member with previously untreated advanced renal cell cancer? Yes ☐ No ☐
  - i. If answer to previous question is 'yes', please provide the following:
    - ☐ Intermediate risk
    - ☐ Poor risk
    - ☐ Other:_____
- B. Please indicate member's ECOG performance status:_____
- C. Please provide member's weight (kg): _____

☐ **Recurrent or Metastatic Head and Neck Cancer**
- A. Histology: ☐ Squamous Cell ☐ Other: _____
- B. Has member previously received platinum-containing chemotherapy (cisplatin or carboplatin)? Yes ☐ No ☐
- C. Please indicate member's ECOG performance status:_____

☐ **Urothelial Bladder Cancer**
- A. Is diagnosis metastatic or unresectable locally advanced cancer? Yes ☐ No ☐
- B. Is nivolumab being used as second-line or greater therapy? Yes ☐ No ☐
- C. Has member previously failed a platinum-containing regimen? Yes ☐ No ☐
- D. Please indicate member's ECOG performance status:_____

☐ **Colorectal Cancer**
- A. Is diagnosis Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR) metastatic colorectal cancer? Yes ☐ No ☐
- B. Has cancer progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan? Yes ☐ No ☐

☐ **Hepatocellular Carcinoma**
- A. Does member have unresectable disease and is not a candidate for transplant? Yes ☐ No ☐
- B. Does member have metastatic disease or extensive liver tumor burden? Yes ☐ No ☐
  - i. Will nivolumab be used as first-line therapy? Yes ☐ No ☐
    - a. Is member ineligible for tyrosine kinase inhibitors or anti-angiogenic agents? Yes ☐ No ☐
  - ii. Will nivolumab be used as second-line or greater therapy? Yes ☐ No ☐

☐ **Esophageal Squamous Cell Carcinoma (ESCC)**
- A. Is diagnosis unresectable advanced, recurrent, or metastatic disease? Yes ☐ No ☐
- B. Will nivolumab be used following prior fluoropyrimidine- and platinum-based chemotherapy? Yes ☐ No ☐

☐ **If answer is none of the above, please indicate diagnosis:**_____

Additional Information:_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on nivolumab? Yes ☐ No ☐
3. Has the member experienced any adverse drug reactions related to nivolumab therapy? Yes ☐ No ☐

*If yes, please specify adverse reactions:*_____

Additional Information:_____

Prescriber Signature:_____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*