OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Yervoy® (Ipilimumab) 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 Yervoy® (ipilimumab) is to be used in combination with Opdivo® (nivolumab), please completely fill out and submit the Opdivo® (nivolumab) prior authorization form (PHARM-64) that is available at: **https://oklahoma.gov/ohca/rxforms.html**

For Initial Authorization:

1. Please indicate the diagnosis and information:

☐ **Unresectable or Metastatic Melanoma**
- A. Will ipilimumab be used in combination with nivolumab as first-line therapy? Yes☐ No☐
- B. Will ipilimumab be used in combination with nivolumab as second-line or subsequent therapy for disease progression if nivolumab was not previously used? Yes☐ No☐
  - i. If answer to previous question is 'yes', please provide the following:
    - a. Has the member previously failed PD-1/PD-L1 inhibitors? Yes☐ No☐
- C. Will ipilimumab be used as a single-agent for first-line therapy? Yes☐ No☐
- D. Will ipilimumab be used as a single-agent for second-line or subsequent lines of therapy? Yes☐ No☐
- E. Will ipilimumab be used as a single-agent for retreatment? Yes☐ No☐
  - i. If answer to previous question is 'yes', please provide the following:
    - a. Did member experience significant systemic toxicity during prior ipilimumab therapy? Yes☐ No☐
    - b. Did disease progress after being stable for greater than six months following completion of a prior course of ipilimumab, and for whom no intervening therapy has been administered? Yes☐ No☐
- F. Please provide member's weight (kg):_____
- G. Please indicate member's ECOG performance status (0-5):_____

☐ **Adjuvant Treatment of Melanoma**
- A. Has member had complete resection of melanoma with lymphadenectomy? Yes☐ No☐
- B. Does member have Stage III disease with regional nodes of >1 mm and no in-transit metastasis? Yes☐ No☐
- C. Will ipilimumab be used as a single-agent? Yes☐ No☐
- D. Please provide member's weight (kg):_____

☐ **Mesothelioma**
- A. Is diagnosis malignant pleural mesothelioma that cannot be surgically removed? Yes☐ No☐
- B. Will ipilimumab be used as first-line therapy? Yes☐ No☐
- C. Will ipilimumab be used in combination with nivolumab? Yes☐ No☐
  - i. Will ipilimumab be used in combination with nivolumab and 2 cycles of platinum-doublet chemotherapy ? Yes☐ No☐
  - ii. Does tumor express PD-L1 ≥1%? Yes☐ No☐

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requesteddata must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *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.*

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Criteria

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

For Initial Authorization (continued)

1. Please indicate the diagnosis and information (continued):

☐ **Esophageal Squamous Cell Carcinoma (ESCC)**
- A. Is diagnosis unresectable advanced or metastatic ESCC? Yes ☐ No ☐
- B. Will ipilimumab be used as first-line therapy? Yes ☐ No ☐
- C. Will ipilimumab be used in combination with nivolumab? Yes ☐ No ☐

☐ **Non-Small Cell Lung Cancer (NSCLC)**
- A. Is diagnosis recurrent, advanced, or metastatic disease? Yes ☐ No ☐
- B. Will ipilimumab be used as first-line therapy? Yes ☐ No ☐
  - i. Epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations? Yes ☐ No ☐
  - ii. Will ipilimumab be used in combination with nivolumab and 2 cycles of platinum-doublet chemotherapy ? Yes ☐ No ☐
  - iii. Does tumor express PD-L1 ≥1%? 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 ☐
- C. Will ipilimumab be used as second-line or greater therapy? Yes ☐ No ☐
- D. Will ipilimumab be used in combination with nivolumab? Yes ☐ No ☐
- E. Has the member previously failed other checkpoint inhibitors? Yes ☐ No ☐

☐ **Renal Cell Cancer**
- 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. Will ipilimumab be used in combination with nivolumab? Yes ☐ No ☐
- C. Has the member previously failed PD-L1 or PD-1 inhibitors? Yes ☐ No ☐
- D. Please provide member's weight (kg): _____

☐ **Colorectal Cancer**
- A. Is diagnosis unresectable or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer? Yes ☐ No ☐
- B. Will ipilimumab be used in combination with nivolumab? Yes ☐ No ☐

☐ **If diagnosis is not listed 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 ipilimumab? Yes ☐ No ☐
3. Has the member experienced adverse drug reactions related to ipilimumab therapy? Yes ☐ No ☐
   If yes, please specify adverse reactions: _____

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. *Failure to complete this form in full will result in processing delays.*

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