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☐
  - 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☐

☐ **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☐

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

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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.

For Initial Authorization (continued)

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

☐ **Small Cell Lung Cancer**
- A. Did disease relapse within 6 months of initial chemotherapy? Yes☐ No☐
- B. Did disease progress on initial chemotherapy? Yes☐ No☐
- C. Will ipilimumab be used in combination with nivolumab? Yes☐ No☐
- D. Please indicate member's ECOG performance status (0-5)_____

☐ **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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