SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
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.**
For Initial Authorization (Initial approval will be for the duration of 6 months):

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☐
- 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):_____

❑ **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)_____

❑ **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:_____

Please complete and return all pages. Failure to complete all pages will result in processing delays.

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.

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

❑ **Renal Cell Cancer (continued)**
- 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 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 ☐
- C. 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: _____

_____

Additional Information: _____

_____

Please complete and return all pages. Failure to complete all pages will result in processing delays.

Please do not send in chart notes. Specific information will be requested if necessary.

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 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.*