

**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**

**SoonerCare Provider ID:** \_\_\_\_\_ **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 requested information:
  - A. Has the member previously failed other PD-1 inhibitors [e.g., Keytruda® (pembrolizumab)]? 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): \_\_\_\_\_
  - Hodgkin Lymphoma
    - A. Is diagnosis relapsed or refractory classical Hodgkin lymphoma? Yes \_\_\_ No \_\_\_
    - B. Is diagnosis lymphocyte-predominant Hodgkin lymphoma? Yes \_\_\_ No \_\_\_
  - Metastatic Non-Small Cell Lung Cancer (NSCLC)
    - A. Tumor histology:  Adenocarcinoma  Squamous Cell  Large Cell  Other: \_\_\_\_\_
    - B. Will nivolumab be used following disease progression on or after platinum-containing chemotherapy (cisplatin or carboplatin)? Yes \_\_\_ No \_\_\_
    - C. 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: \_\_\_\_\_
  - Relapsed or Surgically Unresectable Stage IV Renal Cell Cancer
    - A. Has member previously failed sunitinib, sorafenib, pazopanib, or axitinib? Yes \_\_\_ No \_\_\_
    - B. Please indicate member's ECOG performance status: \_\_\_\_\_
  - 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: \_\_\_\_\_
    - D. Please provide member's weight (kg): \_\_\_\_\_

**Page 1 of 2**

**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.

**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:

Urothelial Bladder Cancer

A. Is diagnosis metastatic or unresectable locally advanced urothelial bladder 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 \_\_\_

If answer is none of the above, please indicate diagnosis: \_\_\_\_\_

**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: \_\_\_\_\_

Draft

**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.*

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| <p><b>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</b></p> <p>University of Oklahoma College of Pharmacy<br/>Pharmacy Management Consultants<br/>Product Based Prior Authorization Unit</p> <p>Fax: 1-800-224-4014<br/>Phone: 1-800-522-0114 Option 4</p> | <p><b>CONFIDENTIALITY NOTICE</b></p> <p><i>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.</i></p> |
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