

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): _____
 - 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 ___
 - 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: _____
 - Renal Cell Cancer
 - 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: _____

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:

- 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): _____
- 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. Is disease relapsed or progressive? Yes ___ No ___
 - B. Has member previously been treated with sorafenib? 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.

<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p style="text-align: center;">University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p style="text-align: center;">Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p style="text-align: center;"><u>CONFIDENTIALITY NOTICE</u></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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