

**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 ___
 - 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): _____

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) _____

Page 1 of 2

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

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 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.

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