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:_____)

***Dose:*** _____ ***Regimen:*** _____ ***Start Date:*** _____

## Billing Provider Information

***SoonerCare Provider ID:*** _____ ***Provider Name:*** _____

***Provider Phone:*** _____ ***Provider Fax:*** _____

## Prescriber Information

***Prescriber NPI:*** _____ ***Prescriber Name:*** _____

***Prescriber Phone:*** _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

## Criteria

**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). _____

☐ If diagnosis is not listed above, please indicate diagnosis:_____

**For Continued Authorization:**

1. Does member have any evidence of progressive disease while on ipilimumab? Yes____ No____
2. Has the member experienced any adverse drug reactions related to ipilimumab therapy? Yes____ No____

*If yes, please specify adverse reactions:*_____

Additional Information:_____

**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. Failure to complete this form in full will result in processing delays.*

| PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO: | CONFIDENTIALITY NOTICE |
|---|---|
| University of Oklahoma College of Pharmacy<br>Pharmacy Management Consultants<br>Product Based Prior Authorization Unit<br><br>Fax: 1-800-224-4014<br>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.* |