Opdivo Qvantig

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Opdivo Qvantig 6795-A SGM SOC 6680-A – 07/2025.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Site of Service Questions (SOS):

A. Where will this drug be administered?
- ❑ Ambulatory surgical, *skip to Clinical Criteria Questions*
- ❑ Home infusion, *skip to Clinical Criteria Questions*
- ❑ Off-campus Outpatient Hospital, *Continue to B*
- ❑ On-campus Outpatient Hospital, *Continue to B*
- ❑ Physician office, *skip to Clinical Criteria Questions*
- ❑ Pharmacy, *skip to Clinical Criteria Questions*

B. Is the patient less than 14 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No, *Continue to C*

C. Is the patient receiving provider-administered combination oncology therapy or other provider-administered drug therapies at the same visit? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to D*

D. Is this request to continue previously established treatment with the requested regimen?
- ❑ No – This is a new therapy request (patient has not received 6 months or more of requested regimen). ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of existing treatment (patient has received requested regimen for 6 months). ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of an existing treatment (patient has received requested regimen for 7 months or greater – initial 6 months plus 45 days grace period), *Continue to E*

E. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre- medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after administration? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to F*

F. Has the patient experienced severe toxicity requiring continuous monitoring (e.g. Grade 2-4 bullous dermatitis, transaminitis, pneumonitis, Stevens-Johnson syndrome, acute pancreatitis, primary adrenal insufficiency aseptic meningitis, encephalitis, transverse myelitis, myocarditis, pericarditis, arrhythmias, impaired ventricular function, or conduction abnormalities)? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to G*

G. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to H*

H. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation. ❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to I*

I. Are ***all*** alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) **greater than** 30 miles from the patient's home? ***ACTION REQUIRED: If Yes, please attach supporting documentation.***
❑ Yes, *Continue to Clinical Criteria Questions* ❑ No, *Continue to Clinical Criteria Questions*

Clinical Criteria Questions:

1. Has the patient experienced disease progression while on a programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor (e.g., Keytruda, Imfinzi)?
❒ Yes, *No Further Questions*
❒ No, *Continue to 2*

2. Is the patient currently receiving treatment with the requested medication?
❒ Yes, *Continue to 56*
❒ No, *Continue to 3*

3. What is the diagnosis?
❒ Renal cell carcinoma, *Continue to 4*
❒ Melanoma, *Continue to 12*
❒ Non-Small Cell Lung Cancer (NSCLC), *Continue to 17*
❒ Head and neck carcinoma, *Continue to 26*
❒ Urothelial carcinoma, *Continue to 30*
❒ Colorectal cancer, *Continue to 38*
❒ Hepatocellular carcinoma, *Continue to 42*
❒ Esophageal carcinoma, *Continue to 45*
❒ Gastric cancer, gastroesophageal junction cancer, and esophageal adenocarcinoma, *Continue to 45*
❒ Other, please specify. _____, *No further questions*

4. Will the requested medication be used in combination with cabozantinib?
❒ Yes, *No Further Questions*
❒ No, *Continue to 5*
5. Will the requested medication be used to treat intermediate or poor risk renal cell carcinoma (RCC)?
❒ Yes, intermediate risk disease, *Continue to 6*
❒ Yes, poor risk disease, *Continue to 6*
❒ No, *Continue to 9*

6. What is the clinical setting in which the requested medication will be used?
❒ Advanced disease *Continue to 7*)
❒ Other, please specify. _____, *Continue to 7*

7. What is the place in therapy in which the requested medication will be used?
❒ First-line treatment, *Continue to 8*)
❒ Subsequent treatment, *Continue to 8*

8. Will the requested medication be used as a single agent following treatment with intravenous nivolumab (Opdivo) and ipilimumab (Yervoy) combination therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

9. What the histology?
❒ Clear cell histology, *Continue to 10*
❒ Non-clear cell histology, *Continue to 11*

10. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *Continue to 11*
❒ Subsequent treatment, *Continue to 11*

11. Will the requested medication be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

12. Will the requested medication be used as adjuvant treatment?
❒ Yes, *Continue to 13*
❒ No, *Continue to 15*

13. What is the clinical setting in which the requested medication will be used?
❒ Stage IIB disease, *Continue to 14*
❒ Stage IIC disease, *Continue to 14*
❒ Stage III disease, *Continue to 14*
❒ Stage IV disease, *Continue to 14*
❒ Other, please specify. _____, *Continue to 14*

14. Will the requested medication be used following complete resection?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

15. What is the clinical setting in which the requested medication will be used?
❒ Unresectable disease, *Continue to 16*
❒ Metastatic disease, *Continue to 16*
❒ Other, please specify. _____, *Continue to 16*

16. Will the requested medication be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

17. What is the clinical setting in which the requested medication will be used?
❒ Metastatic disease, *Continue to 18*
❒ Resectable disease, *Continue to 22*
❒ Other, please specify. _____, *No further questions*

18. Is the patient positive for EGFR mutations or ALK rearrangements?
ACTION REQUIRED: Attach chart note(s) or test results confirming EGFR mutations or ALK rearrangements.
❒ Yes ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 19*
❒ No ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 20*
❒ Unknown, *Continue to 20*

19. Has the disease progressed on FDA-approved targeted therapy?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Has the disease progressed on or after platinum based chemotherapy (e.g., cisplatin, carboplatin)?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Will the requested medication be used as a single agent?

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

22. Is the patient negative for EGFR mutations or ALK rearrangements?
ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming no EGFR mutations or ALK rearrangements.
❒ Yes, ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 23*
❒ No, *Continue to 23*
❒ Unknown, *Continue to 23*

23. What is the requested regimen?
❒ In combination with platinum based chemotherapy, *Continue to 24*
❒ In combination with platinum based chemotherapy (for up to 4 cycles total), followed by single agent adjuvant therapy (for up to 13 cycles), *Continue to 25*
❒ Other, please specify. _____ (If checked, *no further questions*)

24. Will the requested medication be used as neoadjuvant treatment?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

25. Will the requested medication be used for neoadjuvant and adjuvant treatment?
❒ Yes, *No further questions*
❒ No, *No further questions*

26. What is the histology?
❒ Squamous cell histology, *Continue to 27*
❒ Non-squamous cell histology, *Continue to 27*

27. What is the clinical setting in which the requested medication will be used?
❒ Recurrent disease, *Continue to 28*
❒ Metastatic disease, *Continue to 28*
❒ Other, please specify. _____, *Continue to 28*

28. Has the disease progressed on or after platinum based chemotherapy (e.g., cisplatin, carboplatin)?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. Will the requested medication be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

30. What is the requested regimen?
❒ In combination with gemcitabine and cisplatin, *Continue to 31*
❒ As a single agent, *Continue to 33*
❒ Other, please specify. _____ , *No further questions*

31. What is the place in therapy in which the requested medication will be used?
❒ First-line treatment, *Continue to 32*
❒ Subsequent treatment, *Continue to 32*

32. What is the clinical setting in which the requested medication will be used?

❒ Unresectable disease, *No further questions*
❒ Metastatic disease, *No further question*)
❒ Other, please specify. _____, *No further questions*

33. Is the patient at high risk of recurrence after undergoing radical resection?
❒ Yes, *Continue to 34*
❒ No, *Continue to 35*

34. Will the requested medication be used as adjuvant therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

35. What is the clinical setting in which the requested medication will be used?
❒ Locally advanced disease, *Continue to 36*
❒ Metastatic disease, *Continue to 36*
❒ Other, please specify. _____, *Continue to 36*

36. Has the disease progressed during or following platinum-containing chemotherapy (e.g., cisplatin, carboplatin)?
❒ Yes, *No Further Questions*
❒ No, *Continue to 37*

37. Has the disease progressed within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

38. What is the clinical setting in which the requested medication will be used?
❒ Metastatic disease, *Continue to 39*
❒ Other, please specify. _____, *Continue to 39*

39. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 40*
❒ No, *Continue to 40*

40. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)?
ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming microsatellite instability-high or mismatch repair deficient tumor status.
❒ Yes, ***ACTION REQUIRED***: Submit supporting documentation, *Continue to 41*
❒ No, *Continue to 41*
❒ Unknown, *Continue to 41*

41. Has the disease progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

42. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 43*
❒ No, *Continue to 43*

43. Has the patient been treated with sorafenib (Nexavar)?

❒ Yes, *Continue to 44*
❒ No, *Continue to 44*

44. Will the requested medication be used following treatment with intravenous nivolumab (Opdivo) and ipilimumab (Yervoy)?
❒ Yes, *No Further Questions*
❒ No, *No Further Question*
s
45. What is the requested regimen?
❒ As a single agent, *Continue to 46*
❒ In combination with fluoropyrimidine- and platinum-containing chemotherapy, *Continue to 51*
❒ Other, please specify. _____, *No further questions*

46. Has the patient received prior treatment with fluoropyrimidine- and platinum-based chemotherapy?
❒ Yes, *Continue to 47*
❒ No, *Continue to 49*

47. Will the requested medication be used to treat esophageal squamous cell carcinoma (ESCC)?
❒ Yes, *Continue to 48*
❒ No, *Continue to 48*

48. What is the clinical setting in which the requested medication will be used?
❒ Unresectable advanced disease, *No further questions*
❒ Recurrent disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

49. Will the requested medication be used for adjuvant treatment of completely resected esophageal or gastroesophageal junction cancer with residual pathologic disease?
❒ Yes, *Continue to 50*
❒ No, *Continue to 50*

50. Has the patient received neoadjuvant chemoradiotherapy (CRT)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

51. Will the requested medication be used to treat esophageal squamous cell carcinoma (ESCC)?
❒ Yes, *Continue to 52*
❒ No, *Continue to 52*

52. What is the place in therapy in which the requested medication will be used?
❒ First-line treatment, *Continue to 53*
❒ Subsequent treatment, *Continue to 53*

53. What is the clinical setting in which the requested medication will be used?
❒ Unresectable advanced disease, *No Further Questions*
❒ Metastatic disease, *No Further Questions*)
❒ Other, please specify. _____, *No Further Questions*

54. Will the requested medication be used in combination with fluoropyrimidine- and platinum-containing chemotherapy?

❒ Yes, *Continue to 55*
❒ No, *Continue to 55*

55. What is the clinical setting in which the requested medication will be used?
❒ Advanced disease, *No further questions*
❒ Metastatic disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

56. What is the diagnosis?
❒ Renal cell carcinoma, *Continue to 70*
❒ Melanoma, *Continue to 57*
❒ Non-Small Cell Lung Cancer (NSCLC), *Continue to 65*
❒ Head and neck cancer, *Continue to 77*
❒ Urothelial carcinoma, *Continue to 60*
❒ Colorectal cancer, *Continue to 77*
❒ Hepatocellular carcinoma, *Continue to 77*
❒ Esophageal carcinoma, *Continue to 73*
❒ Gastric cancer, gastroesophageal junction cancer, and esophageal adenocarcinoma, *Continue to73*
❒ Other, please specify. _____, *No further questions*

57. Is the requested medication prescribed for the adjuvant treatment of melanoma?
❒ Yes, *Continue to 58*
❒ No, *Continue to 77*

58. Is there evidence of disease recurrence or unacceptable toxicity while on the current regimen?
❒ Yes, *Continue to 59*
❒ No, *Continue to 59*

59. How many continuous months of treatment has the patient received with the requested medication?
_____ months, *No further questions*

60. How is the requested medication being used?
❒ As adjuvant treatment of urothelial carcinoma, *Continue to 61*
❒ First-line treatment in combination with gemcitabine and cisplatin for up to 6 cycles followed by single agent maintenance therapy, *Continue to 63*
❒ Other, *Continue to 77*

61. Is there evidence of disease recurrence or unacceptable toxicity while on the current regimen?
❒ Yes, *Continue to 62*
❒ No, *Continue to 62*

62. How many continuous months of treatment has the patient received with the requested medication?
_____ months, *No further questions*

63. Is there evidence of disease progression or unacceptable toxicity while on the current regimen?
❒ Yes, *Continue to 64*
❒ No, *Continue to 64*

64. How many continuous months of treatment has the patient received with the requested medication?
_____ months, *No further questions*

65. Which of the following applies to the patient's disease?
❒ Treatment of metastatic non-small cell lung cancer (NSCLC), *Continue to 77*
❒ Neoadjuvant treatment of resectable non-small cell lung cancer (NSCLC), *Continue to 68*
❒ Neoadjuvant and adjuvant treatment of resectable NSCLC (up to 4 cycles in combination with chemotherapy, followed by single agent adjuvant treatment up to 13 cycles), *Continue to 66*

66. Is there evidence of disease progression or unacceptable toxicity while on the current regimen?
❒ Yes, *Continue to 67*
❒ No, *Continue to 67*

67. How many continuous months of single agent adjuvant treatment has the patient received with the requested medication?
_____ months, *No further questions*

68. Is there evidence of disease progression or unacceptable toxicity while on the current regimen?
❒ Yes, *Continue to 69*
❒ No, *Continue to 69*

69. How many months has the patient received therapy with the requested medication?
_____ months, *No further questions*

70. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 71*
❒ No, *Continue to 77*

71. Is there evidence of disease progression or unacceptable toxicity while on the current regimen?
❒ Yes, *Continue to 72*
❒ No, *Continue to 72*

72. How many continuous months of treatment has the patient received with the requested medication?
_____ months, *No further questions*

73. Is there evidence of disease progression or unacceptable toxicity while on the current regimen?
❒ Yes, *Continue to 74*
❒ No, *Continue to 74*

74. Which of the following applies to the patient's disease?
❒ Treatment of esophageal squamous cell carcinoma in combination with fluoropyrimidine- and platinum-containing chemotherapy, *Continue to 75*
❒ Treatment of gastric cancer, gastroesophageal junction cancer, and esophageal adenocarcinoma, *Continue to 75*
❒ Adjuvant treatment of resected esophageal or gastroesophageal junction cancer, *Continue to 76*
❒ None of the above, *Continue to 77*

75. How many continuous months of treatment has the patient received with the requested medication?
_____ months, *No further questions*

76. How many continuous months of treatment has the patient received with the requested medication?
_____ months, *No further questions*

77. Is there evidence of disease progression or unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720