Yervoy

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*

What is the ICD-10 code? _____

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

 Standard Oncology SOC Yervoy SGM 1796-A SOC 5374-A – 08/2024.

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?
- ❑ On Campus Outpatient Hospital, *continue to B*
- ❑ Off Campus Outpatient Hospital, *continue to B*
- ❑ Home infusion, *skip to Criteria Questions*
- ❑ Physician office, *skip to Criteria Questions*
- ❑ Ambulatory surgical, *skip to Criteria Questions*
- ❑ Pharmacy, *skip to 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 an infusion? ***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 severe venous access issues that require the use of a special intervention only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to I*

I. 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 J*

J. 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*

Criteria Questions:

1. Is this a request for continuation of therapy (i.e., the patient is currently being treated with the requested drug)?
❒ Yes, *Continue to 63*
❒ No, *Continue to 2*

2. What is the patient's diagnosis?

❒ Cutaneous melanoma (If checked, go to 3)

❒ Uveal melanoma (If checked, go to 13)

❒ Central nervous system (CNS) brain metastases in patients with melanoma (If checked, go to 15)

❒ Non-small cell lung cancer (If checked, go to 16)

❒ Renal cell carcinoma (If checked, go to 20)

❒ Colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma) (If checked, go to 23)

❒ Pleural or peritoneal mesothelioma (including pericardial mesothelioma and tunica vaginalis testis mesothelioma) (If checked, go to 25)

❒ Hepatocellular carcinoma (If checked, go to 26)

❒ Small bowel adenocarcinoma (If checked, go to 27)

❒ Ampullary adenocarcinoma (If checked, go to 30)

❒ Esophageal and Esophagogastric Junction cancers (If checked, go to 33)

❒ Kaposi sarcoma (If checked, go to 39)

❒ Bone cancer (If checked, go to 43)

❒ Biliary tract cancer (Cholangiocarcinoma and Gallbladder Cancer) (If checked, go to 48)

❒ Soft tissue sarcoma (If checked, go to 52)

❒ Merkel cell carcinoma (If checked, go to 54)

❒ Gastric cancer (If checked, go to 56)

❒ Other, please specify. _____ (If checked, *no further questions*)

3. What is the clinical setting in which the requested drug will be used?

❒ Adjuvant treatment (If checked, go to 4)

❒ Neoadjuvant treatment (If checked, go to 11)

❒ Unresectable disease (If checked, go to 8)

❒ Metastatic disease (If checked, go to 8)

❒ Limited resectable local recurrence (If checked, go to 6)

❒ Other, please specify. _____ (If checked, *no further questions*)

4. Is there no evidence of disease following metastasis-directed therapy (e.g., complete resection)?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Will the requested drug be used in any of the following regimens?

❒ As a single agent (for up to 4 doses) (If checked, *no further questions*)

❒ In combination with nivolumab (Opdivo) (for 4 doses followed by nivolumab as a single agent) (If checked, *no further questions*)

❒ Other, please specify. _____ (If checked, *no further questions*)

6. Has the patient received prior treatment with anti-PD-1 therapy?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

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

8. What is the requested regimen?
❒ As a single agent (If checked, *no further questions*)
❒ In combination with nivolumab (Opdivo) (for 4 doses followed by nivolumab as a single agent) (If checked, *no further questions*)
❒ Low dose in combination with pembrolizumab (Keytruda) (If checked, go to 9)
❒ Other, please specify. _____ (If checked, *no further questions*)

9. Has the patient had disease progression following single-agent anti-programmed death 1 (PD-1) therapy?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. What is the place in therapy in which the requested drug will be used?
❒ First-line therapy (If checked, *no further questions*)
❒ Subsequent therapy (If checked, *no further questions*)

11. What is the clinical setting in which the requested drug will be used?
❒ Resectable disease (If checked, go to 12)
❒ Other, please specify. _____ (If checked, go to 12)

12. What is the requested regimen?
❒ In combination with nivolumab (Opdivo) (for 4 doses followed by nivolumab as a single agent) (If checked, *no further questions*)
❒ Other, please specify. _____ (If checked, *no further questions*)

13. What is the clinical setting in which the requested drug will be used?
❒ Metastatic disease (If checked, go to 14)
❒ Unresectable disease (If checked, go to 14)
❒ Other, please specify. _____ (If checked, go to 14)

14. Will the requested drug be used in any of the following regimens?
❒ As a single agent (If checked, *no further questions*)
❒ In combination with nivolumab (Opdivo) (for 4 doses followed by nivolumab as a single agent) (If checked, *no further questions*)
❒ Other, please specify. _____ (If checked, *no further questions*)

15. Will the requested drug be used in any of the following regimens?
❒ As a single agent (If checked, *no further questions*)

❒ In combination with nivolumab (Opdivo) (for 4 doses followed by nivolumab as a single agent) (If checked, *no further questions*)

❒ Other, please specify. _____ (If checked, *no further questions*)

16. Will the requested drug be used in any of the following regimens?

❒ In a regimen containing nivolumab (Opdivo) (If checked, go to 17)

❒ Other, please specify. _____ (If checked, go to 17)

17. What is the clinical setting in which the requested drug will be used?

❒ Recurrent disease (If checked, go to 18)

❒ Metastatic disease (If checked, go to 18)

❒ Advanced disease (If checked, go to 18)

❒ Other, please specify. _____ (If checked, go to 18)

18. Is the patient positive for any of the following: EGFR exon 19 deletions, L858R mutations or ALK rearrangements? ***ACTION REQUIRED***: Please attach documentation of EGFR exon 19 deletions or L858R mutations and ALK rearrangements, where applicable.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)

❒ No ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)

❒ Unknown (If checked, go to 19)

19. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

20. What is the clinical setting in which the requested drug will be used?

❒ Relapsed disease (If checked, go to 21)

❒ Advanced disease (If checked, go to 21)

❒ Stage IV disease (If checked, go to 21)

❒ Other, please specify. _____ (If checked, go to 21)

21. Will the requested drug be used in combination with nivolumab (Opdivo) (for 4 doses, followed by single agent nivolumab)?

❒ Yes, *Continue to 22*

❒ No, *Continue to 22*

22. What is the histology?

❒ Clear cell (If checked, *no further questions*)

❒ Non-clear cell (If checked, *no further questions*)

23. Is the tumor microsatellite instability-high (MSI-H), mismatch repair deficient (dMMR), or polymerase epsilon/delta (POLE/POLD1)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming microsatellite instability-high, mismatch repair deficient, or polymerase epsilon/delta tumor status.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 24)

❒ No (If checked, go to 24)

❒ Unknown (If checked, go to 24)

24. Will the requested drug be used in combination with nivolumab (Opdivo) (for 4 doses followed by nivolumab as a single agent)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

25. Will the requested drug be used in combination with nivolumab (Opdivo)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

26. How will the requested drug be used?
❒ In combination with nivolumab (Opdivo) (4 doses of ipilimumab, followed by Opdivo as a single agent) (If checked, *no further questions*)
❒ Other, please specify. _____ (If checked, *no further questions*)
27. Will the requested drug be used in combination with nivolumab (Opdivo) (for 4 doses followed by nivolumab as a single agent)?
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. What is the clinical setting in which the requested drug will be used?
❒ Advanced disease (If checked, go to 29)
❒ Metastatic disease (If checked, go to 29)
❒ Other, please specify. _____ (If checked, go to 29)
29. Is tumor microsatellite-instability high (MSI-H), mismatch repair deficient (dMMR), or polymerase epsilon/delta (POLE/POLD1)? ACTION REQURED: If Yes, attach chart note(s) or test results confirming microsatellite instability-high, mismatch repair deficient, or polymerase epsilon/delta tumor status.
❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)
❒ No (If checked, *no further questions*)
❒ Unknown (If checked, *no further questions*)
30. Will the requested drug be used in combination with nivolumab (Opdivo) (for 4 doses followed by nivolumab as a single agent)?
❒ Yes, *Continue to 31*
❒ No, *Continue to 31*

31. What is the clinical setting in which the requested drug will be used?
❒ Progressive disease (If checked, go to 32)
❒ Unresectable disease (If checked, go to 32)
❒ Metastatic disease (If checked, go to 32)
❒ Other, please specify. _____ (If checked, go to 32)
32. 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 (If checked, *no further questions*)

❒ No (If checked, *no further questions*)

❒ Unknown (If checked, *no further questions*)

33. 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 (If checked, go to 34)

❒ No (If checked, go to 37)

34. What is the clinical setting in which the requested drug will be used?

❒ Neoadjuvant treatment (If checked, go to 35)

❒ Perioperative treatment (If checked, go to 35)

❒ Other, please specify. _____ (If checked, go to 35)

35. Will the requested drug be used to treat esophageal or esophagogastric junction adenocarcinoma?
❒ Yes, *Continue to 36*
❒ No, *Continue to 36*

36. Is the patient medically fit for surgery?
❒ Yes, *Continue to 38*
❒ No, *Continue to 38*

37. What is the clinical setting in which the requested drug will be used?

❒ The patient is not a surgical candidate (If checked, go to 38)

❒ Unresectable locally advanced disease (If checked, go to 38)

❒ Recurrent disease (If checked, go to 38)

❒ Metastatic disease (If checked, go to 38)

❒ Other, please specify. _____ (If checked, go to 38)

38. Will the requested drug be used in combination with nivolumab (Opdivo)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

39. Which of the following type of Kaposi sarcoma applies to the patient?

❒ Classic Kaposi sarcoma (If checked, go to 40)

❒ Other, please specify. _____ (If checked, go to 40)

40. Will the requested drug be used in combination with nivolumab (Opdivo)?
❒ Yes, *Continue to 41*
❒ No, *Continue to 41*

41. What is the place in therapy in which the requested drug will be used?

❒ First-line treatment (If checked, go to 42)

❒ Subsequent treatment (If checked, go to 42)

42. What is the clinical setting in which the requested drug will be used?

❒ Relapsed/refractory disease (If checked, *no further questions*)

❒ Other, please specify. _____ (If checked, *no further questions*)

43. Will the requested drug be used in combination with nivolumab (Opdivo)?
❒ Yes, *Continue to 44*
❒ No, *Continue to 44*

44. What is the clinical setting in which the requested drug will be used?

❒ Unresectable disease (If checked, go to 45)

❒ Metastatic disease (If checked, go to 45)

❒ Other, please specify. _____ (If checked, go to 45)

45. Is the tumor mutation burden-high (TMB-H) [greater or equal to 10 mutations/megabase (mut/Mb)] tumors? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming tumor mutation burden-high (TMB-H) status.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 46)

❒ No (If checked, go to 46)

❒ Unknown (If checked, go to 46)

46. Has the disease progressed following prior treatment?
❒ Yes, *Continue to 47*
❒ No, *Continue to 47*

47. Are there satisfactory alternative treatment options available for the patient's disease?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

48. Will the requested drug be used in combination with nivolumab (Opdivo)?
❒ Yes, *Continue to 49*
❒ No, *Continue to 49*

49. What is the place in therapy in which the requested drug will be used?

❒ First-line therapy (If checked, go to 50)

❒ Subsequent therapy (If checked, go to 50)

50. What is the clinical setting in which the requested drug will be used?

❒ Unresectable gross residual (R2) disease (If checked, go to 51)

❒ Resected gross residual (R2) disease (If checked, go to 51)

❒ Metastatic disease (If checked, go to 51)

❒ Other, please specify. _____ (If checked, go to 51)

51. Is the tumor mutation burden-high (TMB-H)? ***ACTION REQUIRED***: If Yes, attach chart note(s) or test results confirming mutation burden-high (TMB-H) status.

❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, *no further questions*)

❒ No (If checked, *no further questions*)

❒ Unknown (If checked, *no further questions*)

52. Which of the following type of soft tissue sarcoma applies to the patient?

❒ Extremity/body wall sarcomas (If checked, go to 53)

❒ Head/neck sarcomas (If checked, go to 53)

❒ Retroperitoneal/intra-abdominal sarcomas (If checked, go to 53)

❒ Rhabdomyosarcoma (If checked, go to 53)

❒ Angiosarcoma (If checked, go to 53)

❒ Other, please specify. _____ (If checked, go to 53)

53. Will the requested drug be used in combination with nivolumab (Opdivo)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

54. How will the requested drug be used?

❒ As a single agent (If checked, go to 55)
❒ In combination with nivolumab (Opdivo) (for 4 doses followed by nivolumab as a single agent) (If checked, go to 55)

❒ Other, please specify. _____ (If checked, go to 55)

55. What is the clinical setting in which the requested drug will be used?

❒ Unresectable disease (If checked, *no further questions*)

❒ Recurrent disease (If checked, *no further questions*)

❒ Stage IV disease (If checked, *no further questions*)

❒ Other, please specify. _____ (If checked, *no further questions*)

56. 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 (If checked, go to 57)

❒ No (If checked, go to 57)

❒ Unknown (If checked, go to 57)

57. Has the patient completed endoscopic resection?
❒ Yes, *Continue to 58*
❒ No, *Continue to 59*

58. Is the patient's disease in early stage?
❒ Yes, *Continue to 62*
❒ No, *Continue to 62*

59. Will the requested drug be used to treat gastric adenocarcinoma?
❒ Yes, *Continue to 60*
❒ No, *Continue to 60*

60. What is the clinical setting in which the requested drug will be used?

❒ The patient is not a surgical candidate (If checked, go to 62)

❒ Unresectable disease (If checked, go to 62)

❒ Recurrent disease (If checked, go to 62)

❒ Metastatic disease (If checked, go to 62)

❒ Neoadjuvant treatment (If checked, go to 61)

❒ Perioperative treatment (If checked, go to 61)

❒ Other, please specify. _____ (If checked, *no further questions*)

61. Is the patient medically fit for surgery?

❒ Yes, *Continue to 62*

❒ No, *Continue to 62*

62. Will the requested drug be used in combination with nivolumab (Opdivo)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

63. What is the patient's diagnosis?

❒ Cutaneous melanoma (If checked, go to 64)

❒ Uveal melanoma (If checked, go to 71)

❒ Central nervous system (CNS) brain metastases in patients with melanoma (If checked, go to 71)

❒ Non-small cell lung cancer (If checked, go to 69)

❒ Renal cell carcinoma (If checked, go to 67)

❒ Colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma) (If checked, go to 67)

❒ Pleural mesothelioma (including pericardial mesothelioma and tunica vaginalis testis mesothelioma) (If checked, go to 69)

❒ Peritoneal mesothelioma (If checked, go to 71)

❒ Hepatocellular carcinoma (If checked, go to 67)

❒ Small bowel adenocarcinoma (If checked, go to 71)

❒ Ampullary adenocarcinoma (If checked, go to 71)

❒ Esophageal cancer and Esophagogastric Junction cancers (If checked, go to 69)

❒ Kaposi sarcoma (If checked, go to 71)

❒ Bone cancer (If checked, go to 71)

❒ Biliary tract cancer (Cholangiocarcinoma and Gallbladder Cancer) (If checked, go to 71)

❒ Soft tissue sarcoma (If checked, go to 71)

❒ Merkel cell carcinoma (If checked, go to 71)

❒ Gastric cancer (If checked, go to 69)

❒ Other, please specify. _____ (If checked, *no further questions*)

64. Is the requested drug prescribed for the adjuvant treatment of melanoma?

❒ Yes, *Continue to 65*

❒ No, *Continue to 67*

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

66. How many months of adjuvant treatment has the patient received with the requested drug?
_____ months (*no further questions*)

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

68. How many doses of the requested drug has the patient already received?
_____ doses (*no further questions*)

69. Is there evidence of disease progression or unacceptable toxicity on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *Continue to 70*

70. How many continuous months of treatment has the patient received with the requested drug?
_____ months (*no further questions*)

71. Is there evidence of disease progression or unacceptable toxicity 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)**