BlueCross BlueShield Federal Employee Program

OPDIVO
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Opdivo (nivolumab) injection, for intravenous use

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Is this request for **INITIATION** or **CONTINUATION** of therapy? ***Please select answer below:***
   ❑ **CONTINUATION** of therapy **(PA renewal)**, please answer the questions on **PAGE 4**
   ❑ **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Does the prescriber agree to discontinue treatment for any immune mediated adverse reaction (encephalitis, nephritis, rash, decreased renal function and endocrinopathies) or disease progression? ❑Yes ❑No
4. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No
   ****If YES***, will the patient be advised to use effective contraception during treatment with Opdivo and for 5 months after the last dose? ❑Yes ❑No
5. What is the patient's diagnosis?
   ❑ Merkel cell carcinoma
   ❑ Small cell lung cancer
   ❑ Anal carcinoma
      a. Does the patient have metastatic anal carcinoma? ❑Yes ❑No
   ❑ Colorectal cancer
      a. Does the patient have microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer? ❑Yes ❑No
      b. Has the diagnosis been confirmed by PCR-based assay genetic testing? ❑Yes ❑No
      c. Will the patient use Opdivo in combination with ipilimumab (Yervoy) or as a single agent? ❑Yes***** ❑No
         ****If YES***, please select answer below:
         ❑In combination with ipilimumab (Yervoy), please answer the following question:
            i. Is the disease unresectable or metastatic? ❑Yes ❑No
         ❑As a single agent, please answer the following questions:
            i. Is the disease metastatic?
            ii. Has the disease progressed following treatment with fluoropyrimidine, oxaliplatin, and irinotecan? ❑Yes ❑No
   ❑ Esophageal adenocarcinoma
      a. Does the patient have advanced or metastatic esophageal adenocarcinoma? ❑Yes ❑No
      b. Will Opdivo be used in combination with fluoropyrimidine- and platinum-containing chemotherapy? ❑Yes ❑No
      c. Does the patient have tumors with PD-L1 expression as determined by an FDA-approved test? ❑Yes ❑No
   ❑ Esophageal cancer
      a. Has the patient's esophageal cancer been completely resected? ❑Yes ❑No
      b. Does the patient have residual pathologic disease? ❑Yes ❑No
      c. Has the patient received neoadjuvant chemoradiotherapy (CRT)? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

OPDIVO
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Esophageal squamous cell carcinoma (ESCC)
- a. Is the patient's esophageal squamous cell carcinoma one of the following: unresectable advanced, recurrent, or metastatic? ❑Yes***** ***(*If YES, please answer below)*** ❑No
  - ❑Metastatic ❑Recurrent ❑Unresectable advanced
- b. **If Metastatic or Unresectable Advanced**, please answer the following questions:
  - i. Will Opdivo be used in combination with fluoropyrimidine- and platinum-containing chemotherapy? ❑Yes ❑No*****
    - ****If NO***, will Opdivo be used in combination with ipilimumab (Yervoy)? ❑Yes ❑No
  - ii. Does the patient have tumors with PD-L1 expression as determined by an FDA-approved test? ❑Yes ❑No
  - iii. Will Opdivo be used as first-line treatment? ❑Yes ❑No
- c. Has the patient previously been treated with fluoropyrimidine- and platinum-based chemotherapy? ❑Yes ❑No

❑ Gastric cancer
- a. Does the patient have advanced or metastatic gastric cancer? ❑Yes ❑No
- b. Will Opdivo be used in combination with fluoropyrimidine- and platinum-containing chemotherapy? ❑Yes ❑No
- c. Does the patient have tumors with PD-L1 expression as determined by an FDA-approved test? ❑Yes ❑No

❑ Gastroesophageal junction cancer
- a. Has the patient's gastroesophageal junction cancer been completely resected? ***Please select answer below:***
  - ❑**Yes**: Please answer the following questions:
    - i. Does the patient have residual pathologic disease? ❑Yes ❑No
    - ii. Has the patient received neoadjuvant chemoradiotherapy (CRT)? ❑Yes ❑No
  - ❑**No**: Please answer the following questions:
    - i. Does the patient have advanced or metastatic gastroesophageal junction cancer? ❑Yes ❑No
    - ii. Will Opdivo be used in combination with fluoropyrimidine- and platinum-containing chemotherapy? ❑Yes ❑No
    - iii. Does the patient have tumors with PD-L1 expression as determined by an FDA-approved test? ❑Yes ❑No

❑ Head and neck carcinoma
- a. Does the patient have recurrent or metastatic squamous cell carcinoma of the head and neck? ❑Yes ❑No
- b. Did the patient experience disease progression while on or after platinum-based chemotherapy? ❑Yes ❑No

❑ Hepatocellular carcinoma
- a. Does the patient have unresectable or metastatic hepatocellular carcinoma (HCC)? ❑Yes ❑No
- b. Will the patient use Opdivo as first-line treatment? ❑Yes ❑No
- c. Has the patient had prior treatment with sorafenib (Nexavar)? ❑Yes ❑No
- d. Will the patient use Opdivo in combination with ipilimumab (Yervoy)? ❑Yes ❑No

❑ Hodgkin lymphoma
- a. Does the patient have relapsed or progressed classical Hodgkin lymphoma? ❑Yes ❑No
- b. Has the patient had autologous hematopoietic stem cell transplantation (HSCT) and post-transplantation therapy with brentuximab vedotin (Adcetris)? ❑Yes ❑No*****
  - ****If NO***, has the patient had three or more lines of systemic therapy that includes autologous HSCT? ❑Yes ❑No

❑ Melanoma
- a. Is the patient's melanoma post resection? ***Please select answer below:***
  - ❑**Yes:** Please answer the following questions:
    - i. Is Opdivo being used as adjuvant treatment of melanoma post resection? ❑Yes ❑No
    - ii. Which stage of melanoma does the patient have? ***Please select answer below:***
      - ❑Stage 0 ❑Stage I ❑Stage IIA ❑Stage IIB ❑Stage IIC ❑Stage III ❑Stage IV
  - ❑**No**: Please answer the following questions:
    - i. Does the patient have unresectable or metastatic melanoma? ❑Yes ❑No
    - ii. Will the patient be using Opdivo in combination with ipilimumab (Yervoy) or as a single agent? ❑Yes***** ❑No
      - ****If YES***, select one of the following: ❑In combination with Yervoy **OR** ❑As a single agent

❑ Mesothelioma
- a. Does the patient have unresectable malignant pleural mesothelioma? ❑Yes ❑No
- b. Will the patient use Opdivo as first-line treatment in combination with ipilimumab (Yervoy)? ❑Yes ❑No

PLEASE PROCEED TO PAGE 3 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

OPDIVO
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Renal cell carcinoma

a. Does the patient have a diagnosis of advanced renal cell carcinoma? ❑Yes ❑No

b. Will the patient use Opdivo as first-line treatment in combination with cabozantinib (Cabometyx)? ❑Yes ❑No

c. Has the patient had prior treatment with anti-angiogenic therapy? ❑Yes ❑No

d. Is the patient considered to have an intermediate or poor prognosis? ❑Yes* ❑No

If YES, will the patient use Opdivo in combination with ipilimumab (Yervoy)? ❑Yes ❑No

❑ Non-small cell lung cancer (NSCLC)

a. Does the patient have resectable, metastatic, or recurrent non-small cell lung cancer? ❑Yes* ❑No

If YES, please select answer below:

❑**Metastatic:** Does the patient have an EGFR or ALK genomic tumor aberration? ***Please select answer below:***

❑**Yes**: Please answer the following questions:

i. Did the patient experience disease progression while on or after platinum-based chemotherapy? ❑Yes ❑No

ii. Has the patient experienced disease progression on FDA approved therapy? ❑Yes ❑No

❑**No:** Please answer the following questions:

i. Did the patient experience disease progression while on or after platinum-based chemotherapy? ❑Yes ❑No

ii. Does the patient have tumors with PD-L1 expression as determined by an FDA-approved test? ❑Yes* ❑No

If YES, will Opdivo be used as first-line treatment in combination with ipilimumab (Yervoy)? ❑Yes ❑No

iii. Will Opdivo be used as first-line treatment in combination with ipilimumab (Yervoy) and two cycles of platinum-doublet chemotherapy? ❑Yes ❑No

❑**Recurrent:** Please answer the following questions:

i. Does the patient have an EGFR or ALK genomic tumor aberration? ❑Yes ❑No

ii. Is Opdivo being used as first line treatment? ❑Yes* ❑No

If YES, will Opdivo be used in combination with ipilimumab (Yervoy) and two cycles of platinum-doublet chemotherapy? ❑Yes ❑No

❑**Resectable:** Please answer the following questions:

i. Is the patient's tumors greater than or equal to 4 centimeters **OR** node positive? ❑Yes ❑No

ii. Will Opdivo be used in combination with platinum-doublet chemotherapy in the neoadjuvant setting? ❑Yes ❑No

❑ Urothelial carcinoma (cancer)

a. Is the patient at high risk of recurrence after undergoing radical resection? ❑Yes* ❑No

If YES, will Opdivo be used as adjuvant treatment? ❑Yes ❑No

b. Is the patient's urothelial carcinoma one of the following: unresectable, metastatic, or locally advanced? ❑Yes* ❑No

If YES, please select one of the following: ❑Locally advanced ❑Metastatic ❑Unresectable

c. **If Locally Advanced or Metastatic**: Did the patient experience disease progression while on or after platinum-based chemotherapy? ❑Yes ❑No*

If NO, has the patient had disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy? ❑Yes ❑No

d. **If Metastatic or Unresectable**: Will Opdivo be used as first-line treatment in combination with cisplatin and gemcitabine? ❑Yes ❑No

❑ Other ***(please specify):*** _____

BlueCross BlueShield Federal Employee Program

OPDIVO
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

CONTINUATION OF THERAPY (PA RENEWAL)

Opdivo (nivolumab) injection, for intravenous use

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Is this request for **INITIATION** or **CONTINUATION** of therapy? ***Please select answer below:***
   ❑ **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑ **CONTINUATION** of therapy **(PA renewal)**, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient had disease progression or unacceptable toxicity while on the requested therapy? ❑Yes ❑No
4. Does the prescriber agree to discontinue treatment for any immune mediated adverse reaction (encephalitis, nephritis, rash, decreased renal function and endocrinopathies) or disease progression? ❑Yes ❑No
5. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised to use effective contraception during treatment with Opdivo and for 5 months after the last dose? ❑Yes ❑No
6. What is the patient's diagnosis?
   ❑ Merkel cell carcinoma
   ❑ Small cell lung cancer
   ❑ Anal carcinoma
      a. Does the patient have metastatic anal carcinoma? ❑Yes ❑No
   ❑ Colorectal cancer
      a. Does the patient have microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer? ❑Yes ❑No
      b. Is the disease unresectable or metastatic? ❑Yes ❑No
   ❑ Esophageal adenocarcinoma
      a. Does the patient have advanced or metastatic esophageal adenocarcinoma? ❑Yes ❑No
      b. Will Opdivo be used in combination with fluoropyrimidine- and platinum-containing chemotherapy? ❑Yes ❑No
   ❑ Esophageal cancer
      a. Has the patient's esophageal cancer been completely resected? ❑Yes ❑No
      b. Does the patient have residual pathologic disease? ❑Yes ❑No
   ❑ Esophageal squamous cell carcinoma (ESCC)
      a. Is the patient's esophageal squamous cell carcinoma one of the following: unresectable advanced, recurrent, or metastatic? ❑Yes* ***(*If YES, please select answer below)*** ❑No
         ❑Metastatic ❑Recurrent ❑Unresectable advanced
      b. **If Metastatic or Unresectable Advanced**: Will Opdivo be used in combination with fluoropyrimidine- and platinum-containing chemotherapy? ❑Yes ❑No*
         If NO, will Opdivo be used in combination with ipilimumab (Yervoy)? ❑Yes ❑No
      c. Has the patient had prior treatment with fluoropyrimidine- and platinum-based chemotherapy? ❑Yes ❑No

PLEASE PROCEED TO PAGE 5 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

OPDIVO
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 5 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Gastric cancer
- a. Does the patient have advanced or metastatic gastric cancer? ❑Yes ❑No
- b. Will Opdivo be used in combination with fluoropyrimidine- and platinum-containing chemotherapy? ❑Yes ❑No

❑ Gastroesophageal junction cancer
- a. Has the patient's gastroesophageal junction cancer been completely resected? ***Please select answer below:***
  - ❑**Yes**: Does the patient have residual pathologic disease? ❑Yes ❑No
  - ❑**No**: Please answer the following questions:
    - i. Does the patient have advanced or metastatic gastroesophageal junction cancer? ❑Yes ❑No
    - ii. Will Opdivo be used in combination with fluoropyrimidine- and platinum-containing chemotherapy? ❑Yes ❑No

❑ Head and neck carcinoma
- a. Does the patient have recurrent or metastatic squamous cell carcinoma of the head and neck? ❑Yes ❑No

❑ Hepatocellular carcinoma
- a. Does the patient have unresectable or metastatic hepatocellular carcinoma (HCC)? ❑Yes ❑No

❑ Hodgkin lymphoma
- a. Does the patient have relapsed or progressed classical Hodgkin lymphoma? ❑Yes ❑No

❑ Melanoma
- a. Is the patient's melanoma post resection? ***Please select answer below:***
  - ❑**Yes:** Please answer the following questions:
    - i. Is Opdivo being used as adjuvant treatment of melanoma post resection? ❑Yes ❑No
    - ii. Which stage of melanoma does the patient have? ***Please select answer below:***
      - ❑Stage 0 ❑Stage I ❑Stage IIA ❑Stage IIB ❑Stage IIC ❑Stage III ❑Stage IV
  - ❑**No**: Does the patient have unresectable or metastatic melanoma? ❑Yes ❑No

❑ Mesothelioma
- a. Does the patient have unresectable malignant pleural mesothelioma? ❑Yes ❑No
- b. Was the patient using Opdivo in combination with ipilimumab (Yervoy)? ❑Yes ❑No

❑ Non-small cell lung cancer (NSCLC)
- a. Does the patient have resectable, metastatic, or recurrent non-small cell lung cancer? ❑Yes***** ❑No
  - ****If YES,*** please select answer below:
  - ❑**Metastatic:** Was the patient using Opdivo in combination with ipilimumab (Yervoy)? ❑Yes ❑No
  - ❑**Recurrent:** Was the patient using Opdivo in combination with ipilimumab (Yervoy)? ❑Yes ❑No
  - ❑**Resectable:** Please answer the following questions:
    - i. Does the patient have an EGFR or ALK genomic tumor aberration? ❑Yes ❑No
    - ii. Did the patient experience disease progression while on or after platinum-based chemotherapy? ❑Yes ❑No

❑ Renal cell carcinoma
- a. Does the patient have a diagnosis of advanced renal cell carcinoma? ❑Yes ❑No
- b. Was the patient using Opdivo in combination with cabozantinib (Cabometyx)? ❑Yes ❑No

❑ Urothelial carcinoma
- a. Is the patient at high risk of recurrence after undergoing radical resection? ❑Yes***** ❑No
  - ****If YES***, will the patient be using Opdivo as adjuvant treatment? ❑Yes ❑No
- b. Does the patient have unresectable or metastatic urothelial carcinoma? ❑Yes***** ❑No
  - ****If YES***, will Opdivo be used as first-line treatment in combination with cisplatin and gemcitabine? ❑Yes ❑No

❑ Other ***(please specify)***: _____