

physician portion and submit this completed form.

OPDIVO PRIOR APPROVAL REQUEST

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

Federal Employee Program. **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

Patient Information (required)		Provider Information (required)			
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: Dale	□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 <u>PAGE 4</u>

□ 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?
 - Herkel 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? \Box Yes* \Box No **If YES*, please select answer below:
 - In combination with ipilimumab (Yervoy), please answer the following question:
 - i. Is the disease unresectable or metastatic? \Box Yes \Box 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? **U**Yes **U**No
 - Esophageal adenocarcinoma
 - a. Does the patient have advanced or metastatic esophageal adenocarcinoma? UYes No
 - b. Will Opdivo be used in combination with fluoropyrimidine- and platinum-containing chemotherapy? \Box Yes \Box No
 - c. Does the patient have tumors with PD-L1 expression as determined by an FDA-approved test? \Box Yes \Box 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



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PRIOR APPROVAL REQUEST

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	PAGE 2 - PHYSICIA	N COMPLETES	
Patient Name:	DOB:	Patient ID: R	
	geal squamous cell carcinoma one o	f the following: unresectable advanced, rec	urrent, or
	If YES, please answer below) DNo DRecurrent DUnresectable adv	vanaad	
	sectable Advanced, please answer		
i. Will Opdivo be use	ed in combination with fluoropyrimi	idine- and platinum-containing chemothera ilimumab (Yervoy)? □Yes □No	py? □Yes □No*
ii. Does the patient h		as determined by an FDA-approved test?	□Yes □No
c. Has the patient previou Gastric cancer	sly been treated with fluoropyrimid	ine- and platinum-based chemotherapy?	Yes DNo
-	dvanced or metastatic gastric cance		
-		e- and platinum-containing chemotherapy? termined by an FDA-approved test?	
· · ·		mpletely resected? Please select answer belo	w:
	ent have residual pathologic disease	$? \Box Yes \Box No$	
* *	ent received neoadjuvant chemoradi		
No : Please answer th	•	r, c,	
	•	troesophageal junction cancer? Yes	INo
ii. Will Opdivo	be used in combination with fluoro	pyrimidine- and platinum-containing chem ession as determined by an FDA-approved to	otherapy? Yes No
Head and neck carcinoma			
-	-	l carcinoma of the head and neck? □Yes	
		after platinum-based chemotherapy? □Ye	s 🗖No
Hepatocellular carcinoma			
-	-	lular carcinoma (HCC)? U Yes U No	
	odivo as first-line treatment? □Yes		
	or treatment with sorafenib (Nexava		
	odivo in combination with ipilimum	ab (Yervoy)? UYes UNo	
	alamaad on macanaged alagaigal U.d.	gkin lymphoma? 🛛 Yes 🖾 No	
-	elapsed or progressed classical Hod	• • •	on the new with
	Adcetris)? U Yes U No*	nsplantation (HSCT) and post-transplantati	ion therapy with
		nic therapy that includes autologous HSCT	V DVes DNo
☐ Melanoma	int had three of more lines of system	ne therapy that mendes autologous moet.	
	ma post resection? Please select ans	swer below:	
	he following questions:		
	ing used as adjuvant treatment of mo	elanoma post resection? Yes No	
1	of melanoma does the patient have		
-	-	B Stage IIC Stage III Stage IV	
No : Please answer th	• • •		
	nt have unresectable or metastatic n	nelanoma? 🛛 Yes 🖓 No	
-	•	with ipilimumab (Yervoy) or as a single ag bination with Yervoy <u>OR</u> □As a sing	
Mesothelioma			

Mesothelioma

- a. Does the patient have unresectable malignant pleural mesothelioma? \Box Yes \Box 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

PAGE 2 of 5



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	PAGE 3 - PHYSICIAN COMPLETES
Patient Name:	DOB: Patient ID: R
b. Will the patient use Opdivc. Has the patient had prior trd. Is the patient considered to	agnosis of advanced renal cell carcinoma? Yes No o as first-line treatment in combination with cabozantinib (Cabometyx)? Yes No reatment with anti-angiogenic therapy? Yes No o have an intermediate or poor prognosis? Yes* No use Opdivo in combination with ipilimumab (Yervoy)? Yes No
□ Non-small cell lung cancer (N	
* <i>If YES</i> , please select ar Destruction Destruction	ctable, metastatic, or recurrent non-small cell lung cancer? Yes* No nswer below: patient have an EGFR or ALK genomic tumor aberration? <i>Please select answer below:</i> ease answer the following questions:
i.	Did the patient experience disease progression while on or after platinum-based chemotherapy? \Box Yes \Box No
ii.	Has the patient experienced disease progression on FDA approved therapy? Yes No
□No: Ple	ase answer the following questions:
	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
	* <i>If YES</i> , 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
	swer the following questions: e patient have an EGFR or ALK genomic tumor aberration? Yes No
* <i>If Y</i> doubl Resectable: Please an	vo being used as first line treatment? \Box Yes* \Box No <i>ES</i> , will Opdivo be used in combination with ipilimumab (Yervoy) and two cycles of platinum- let chemotherapy? \Box Yes \Box No swer the following questions: atient's tumors greater than or equal to 4 centimeters OR node positive? \Box Yes \Box No
ii. Will Op	polivo be used in combination with platinum-doublet chemotherapy in the neoadjuvant $2 \Box Yes \Box No$
Urothelial carcinoma (cancer)	
	of recurrence after undergoing radical resection? Yes* No e used as adjuvant treatment? Yes No
•	carcinoma one of the following: unresectable, metastatic, or locally advanced? \Box Yes* \Box No one of the following: \Box Locally advanced \Box Metastatic \Box Unresectable
chemotherapy? Yes	
* <i>If NO</i> , has the patient containing chemotherap	had disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum- by? \Box Yes \Box No
d. If Metastatic or Unresed gemcitabine? Yes	etable: Will Opdivo be used as first-line treatment in combination with cisplatin and No

Other (please specify):

BlueCross BlueShield

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Patient Information (required)		Provider Information (required)			
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: Dale	□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 <u>PAGE 1</u>

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? \Box Yes \Box 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? **D**Yes **D**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? \Box Yes \Box No
- Esophageal adenocarcinoma
 - a. Does the patient have advanced or metastatic esophageal adenocarcinoma? \Box Yes \Box No
 - b. Will Opdivo be used in combination with fluoropyrimidine- and platinum-containing chemotherapy? **U**Yes **U**No
- Esophageal cancer
 - a. Has the patient's esophageal cancer been completely resected? \Box Yes \Box 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? \Box Yes* (**If YES, please select answer below*) \Box No
 - □Metastatic □Recurrent □Unresectable advanced
 - b. **If Metastatic or Unresectable Advanced**: Will Opdivo be used in combination with fluoropyrimidine- and platinumcontaining 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

PAGE 4 of 5

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Opdivo – FEP MD Fax Form Revised 7/11/2025



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sician portion and submit this comp	leted form.			

PAGE 5 - PHYSICIAN COMPLETES

Patient Name: DOB: Patient ID: R Gastric cancer a. Does the patient have advanced or metastatic gastric cancer? **D**Yes **D**No b. Will Opdivo be used in combination with fluoropyrimidine- and platinum-containing chemotherapy? \Box Yes \Box No Gastroesophageal junction cancer a. Has the patient's gastroesophageal junction cancer been completely resected? *Please select answer below:* \Box Yes: Does the patient have residual pathologic disease? \Box Yes \Box No **No:** Please answer the following questions: i. Does the patient have advanced or metastatic gastroesophageal junction cancer? \Box Yes \Box No ii. Will Opdivo be used in combination with fluoropyrimidine- and platinum-containing chemotherapy? \Box Yes \Box No Head and neck carcinoma a. Does the patient have recurrent or metastatic squamous cell carcinoma of the head and neck? \Box Yes \Box No Hepatocellular carcinoma a. Does the patient have unresectable or metastatic hepatocellular carcinoma (HCC)? **\Box** Yes **\Box** No Hodgkin lymphoma a. Does the patient have relapsed or progressed classical Hodgkin lymphoma? \Box Yes \Box 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? **D**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 \Box No: Does the patient have unresectable or metastatic melanoma? \Box Yes □No Mesothelioma a. Does the patient have unresectable malignant pleural mesothelioma? \Box Yes \Box No b. Was the patient using Opdivo in combination with ipilimumab (Yervoy)? **D**Yes **D**No □ Non-small cell lung cancer (NSCLC) a. Does the patient have resectable, metastatic, or recurrent non-small cell lung cancer? **D**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)? □No **Resectable:** Please answer the following questions: i. Does the patient have an EGFR or ALK genomic tumor aberration? Ues No ii. Did the patient experience disease progression while on or after platinum-based chemotherapy? Renal cell carcinoma a. Does the patient have a diagnosis of advanced renal cell carcinoma? \Box Yes \Box No b. Was the patient using Opdivo in combination with cabozantinib (Cabometyx)? \Box Yes \Box No Urothelial carcinoma a. Is the patient at high risk of recurrence after undergoing radical resection? \Box Yes* \Box No **If YES*, will the patient be using Opdivo as adjuvant treatment? **U**Yes **U**No b. Does the patient have unresectable or metastatic urothelial carcinoma? \Box Yes* \Box No *If YES, will Opdivo be used as first-line treatment in combination with cisplatin and gemcitabine? \Box Yes \Box No Other (*please specify*):