Yervoy

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

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: _____ **NPI#:** _____
Specialty: _____ **HPHC Provider ID#:**_____
Physician Office Telephone: _____ **Physician Office Fax:** _____

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

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

Additional Demographic Information:

Please indicate the place of service for the requested drug:
❑ Ambulatory Surgical ❑ Home ❑ Inpatient Hospital ❑ Off Campus Outpatient Hospital ❑ On Campus Outpatient Hospital ❑ Office ❑ Pharmacy

Drug Information:
*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

Criteria Questions:

1. What is the patient's diagnosis?
   ❑ Melanoma
   ❑ Other
2. What is the ICD-10 code?_____
3. Has the patient received a prior course of Yervoy? ❑ Yes ❑ No
4. Did the patient experience a positive clinical response (i.e., no disease recurrence and acceptable levels of toxicity)?
   If yes, please provide supporting documentation (i.e., medical records).
   ❑ Yes ❑ No
5. Is Yervoy being used to treat metastatic CNS lesions? *If yes, Skip to #14* ❑ Yes ❑ No
6. Is the disease unresectable or metastatic? ***If yes, please provide supporting documentation (i.e., medical records)***.
   ❑ Yes ❑ No *If No, skip to #12*
7. What is the member's Eastern Cooperative Oncology Group (ECOG) status? _____
   Please provide documentation supporting the ECOG status.

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8. What is the prescribed regimen?
   - ❑ Yervoy monotherapy *No further questions*
   - ❑ Yervoy and nivolumab (Opdivo)
   - ❑ Other _____

9. What is the intent of therapy?
   - ❑ First-line therapy
   - ❑ Second-line therapy (following disease progression)
   - ❑ Other _____

10. Has the patient previously received therapy with PD-1 agents (e.g., Keytruda [pembrolizumab])?
    ❑ Yes ❑ No *No further questions.*

11. Did the patient experience a positive clinical response (i.e., stable disease of at least 3 months with no significant side effects)? ***If yes, please provide supporting documentation (i.e., medical records).***
    ❑ Yes ❑ No *No further questions*

12. Does the patient have stage III disease? ***If yes, please provide supporting documentation (i.e., medical records).***
    ❑ Yes ❑ No

13. Will Yervoy be used as adjuvant therapy following complete resection and lymphadenectomy? ***If yes, please provide supporting documentation of complete resection and lymphadenectomy (i.e., medical records).***
    ❑ Yes ❑ No *No further questions*

14. Was Yervoy active against the primary tumor (melanoma)? ❑ Yes ❑ No

15. Is the disease recurrent? ❑ Yes ❑ No

16. Will Yervoy be used as a single agent (monotherapy)? ❑ Yes ❑ No

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)**

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