



Opdivo (nivolumab)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
Urgency: <input type="checkbox"/> Standard <input type="checkbox"/> Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)					
Medication Requested: <input type="checkbox"/> Opdivo 40mg vial <input type="checkbox"/> Opdivo 100mg vial <input type="checkbox"/> Opdivo 120 mg vial <input type="checkbox"/> Opdivo 240mg vial Directions for use: Quantity: Duration of therapy: J-Code: ICD10:					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): **Cigna's nationally preferred specialty pharmacy **Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557					
Facility and/or doctor dispensing and administering medication: Facility Name: State: Tax ID#: Address (City, State, Zip Code):					
Is the patient a candidate for home infusion? Yes <input type="checkbox"/> No <input type="checkbox"/> Does the physician have an in-office infusion site? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diagnosis related to use: <input type="checkbox"/> ampullary adenocarcinoma <input type="checkbox"/> anal cell carcinoma <input type="checkbox"/> anaplastic thyroid carcinoma <input type="checkbox"/> biliary tract carcinoma <input type="checkbox"/> bone cancer (including chondrosarcoma, chordoma, Ewing sarcoma, and osteosarcoma) <input type="checkbox"/> brain metastases <input type="checkbox"/> cervical carcinoma <input type="checkbox"/> chronic lymphocytic leukemia/small lymphocytic lymphoma for histologic (Richter's) transformation to diffuse large B-cell lymphoma <input type="checkbox"/> colorectal cancer (CRC) <input type="checkbox"/> endometrial carcinoma <input type="checkbox"/> esophageal adenocarcinoma <input type="checkbox"/> esophageal squamous cell carcinoma (ESCC) <input type="checkbox"/> esophageal cancer <input type="checkbox"/> extranodal NK/T-cell lymphoma, nasal type <input type="checkbox"/> gastric cancer <input type="checkbox"/> gastroesophageal junction (GEJ) cancer <input type="checkbox"/> gestational trophoblastic neoplasia (GTN) <input type="checkbox"/> hepatocellular carcinoma (HCC) <input type="checkbox"/> Hodgkin lymphoma (HL) <input type="checkbox"/> Kaposi sarcoma					

- malignant pleural mesothelioma (MPM)
- melanoma
- Merkel cell carcinoma (MCC)
- nasopharyngeal carcinoma
- Non-pancreatic neuroendocrine tumor (non-pNET)
- non-small cell lung cancer (NSCLC) first-line treatment
- non-small cell lung cancer (NSCLC) neoadjuvant therapy/treatment
- non-small cell lung cancer (NSCLC) subsequent treatment
- pancreatic adenocarcinoma
- primary mediastinal large B-cell lymphoma (PMLBCL)
- renal cell carcinoma (RCC)
- small bowel adenocarcinoma (SBA)
- soft tissue sarcomas (including angiosarcoma, those of the extremities/body wall/head/neck/retroperitoneal/intra-abdominal, and rhabdomyosarcoma)
- squamous cell vulvar carcinoma
- small cell lung cancer (SCLC)
- urothelial carcinoma (UCC, also transitional cell carcinoma [TCC])
- squamous cell carcinoma of the head and neck (SCCHN)
- other (*please specify*):

Clinical Information

(if nasopharyngeal carcinoma) Has the patient been started on Opdivo? Yes No

(if no, and nasopharyngeal carcinoma) Does the patient have recurrent or metastatic non-keratinizing disease? Yes No

(if yes and nasopharyngeal carcinoma) Is this medication being used as subsequent therapy? Yes No

(if no, and nasopharyngeal carcinoma) Does the patient have recurrent, unresectable, oligometastatic, or metastatic disease? Yes No

(if yes and nasopharyngeal carcinoma, if first line treatment) Will this medication be used in combination with cisplatin and gemcitabine? Yes No

(if yes and nasopharyngeal carcinoma) The covered alternative is Loqtorzi (toripalimab intravenous infusion) [may require prior authorization]. If the patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions the patient experienced. If the patient has NOT tried this drug, please provide details why the patient can't try this alternative.

(if nasopharyngeal carcinoma) Per the information provided above, which of the following is true for the patient in regard to the covered alternative?

- The patient tried the alternative, but it didn't work well enough
- The patient tried the alternative, but they did not tolerate it
- The patient cannot try the alternative because of a contraindication to this drug
- Other

Is this new start or continuation of therapy? new start continuation of therapy
 (if continuation of therapy) Is the patient responding to therapy OR is the patient NOT having disease progression while on the requested drug? Yes No

*****This drug requires supportive documentation (i.e. genetic testing, chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.**

(if anal cell carcinoma, endometrial, non-pNET, squamous vulvar) Was the patient previously treated with only one other chemotherapy regimen for this diagnosis? Yes No

(if non-pNET and previous first line chemo) Did the patient experience progression (or disease worsening) while on first line chemotherapy? Yes No

(if endometrial) Does the patient have recurrent or metastatic disease? Yes No

(if not recurrent or metastatic) Does the patient have high-risk mismatch repair deficient (dMMR) tumors? Yes No

(if bone cancer) Does the patient have tissue tumor mutation burden-high (TMB-H) tumors with 10 or more mutations per megabase? Yes No

(if bone cancer) Has the patient previously been treated with any therapy for this diagnosis? Yes No

(if yes) Did the patient have disease progression with the previous treatment? Yes No

(if bone cancer) Are there any satisfactory alternative options available for treatment? Yes No

(if brain mets) Is melanoma the primary tumor/site? Yes No

(if no) What is the primary tumor/site _____

(if brain mets) Does the patient have recurrent disease? Yes No

(if CRC) Does the patient have unresectable, advanced, or metastatic disease? Yes No

(if CRC or SBA) Does the patient's disease have deficient mismatch repair (dMMR) or microsatellite instability-high (MSI-H)? Yes No

(if CLL/SLL) Does the patient have the del(17p)/TP53 mutation? Yes No

(if no) Is the patient refractory to chemotherapy and unable to receive chemoimmunotherapy? Yes No

(if ESCC) Is this the first therapy the patient has received for this diagnosis? Yes No

(if yes) Will the patient be using Opdivo in combination with Yervoy (ipilimumab)? Yes No

(if no) Was the patient previously treated with fluoropyrimidine (like capecitabine [Xeloda], floxuridine, and fluorouracil [5-FU, Adrucil]) and platinum-based chemotherapy (like carboplatin or cisplatin) for this diagnosis? Yes No

(if yes) Does the patient have unresectable advanced, or metastatic disease? Yes No

(if gastric, GEJ or esophageal adenocarcinoma) Does the patient have advanced or metastatic disease? Yes No

(if yes) Is/Will the requested medication (be)ing given in combination with a fluoropyrimidine (like capecitabine [Xeloda], floxuridine, and fluorouracil [5-FU, Adrucil]) and platinum (like carboplatin or cisplatin)-containing chemotherapy? Yes No

(if esophageal OR GEJ cancer except ESCC) Does the patient have residual disease after complete resection and neoadjuvant chemoradiation? Yes No

(if yes) Is the requested medication being used as adjuvant therapy? Yes No

(if extranodal NK/T-cell lymphoma [nasal type] or PMLBCL) Does the patient have relapsed or refractory disease? Yes No

(if extranodal NK/T-cell lymphoma) Is the patient's disease nasal type? Yes No

(if extranodal NK/T-cell lymphoma, nasal type) Will the requested medication be used following additional therapy with an alternate combination chemotherapy regimen that is asparaginase-based? Yes No

(if yes) Has the patient previously used the additional alternate therapy? Yes No

(if GTN) Does the patient have recurrent or progressive disease? Yes No

(if GTN) Was the patient previously treated with a platinum/etoposide-containing regimen? Yes No

(if HCC) Was the patient previously treated with Nexavar (sorafenib)? Yes No

(if no Nexavar and HCC) Does the patient have metastatic or unresectable disease? Yes No

(if no Nexavar and HCC) Will the requested medication be used in combination with ipilimumab as first line treatment? Yes No

(if HL, classical type) Which type of Hodgkin lymphoma does the patient have?
 classical type
 nodular lymphocyte predominant type
 other

(if HL, classical type) Which of the following applies to the patient?
 Relapsed or refractory disease
 Palliative therapy and patient is older than 60 years
 Stage III or IV disease that is previously untreated
 other

(if Stage III or IV disease that is previously untreated) Will the requested medication be used in combination with doxorubicin, vinblastine, and dacarbazine (AVD)? Yes No

(if relapsed/refractory) Has the patient undergone an autologous stem cell transplant? Yes No

(if yes) After the transplant, did the patient have therapy with Adcetris? Yes No

(if melanoma) How is this medication being used for this diagnosis?

- Adjuvant treatment for metastatic disease that has spread to the lymph nodes
- Adjuvant treatment for stage IIB/C disease
- Single-agent therapy
- In combination with ipilimumab (generic for Yervoy)
- Other

(if bone cancer OR melanoma & and not adjuvant) Does the patient have metastatic or unresectable disease? Yes No

(if melanoma & adjuvant tx) Did the patient have complete resection of the melanoma? Yes No

(if MPM) Which of the following applies?

- Drug requested is being used as single-agent therapy
- Drug requested is being given in combination with Yervoy
- other

(if NSCLC) Which best describes Opdivo's role in therapy?

- Opdivo is being given as first line treatment
- Opdivo is being given as subsequent therapy.
- Opdivo is being given as neoadjuvant therapy.
- unknown

(if cervical carcinoma) Is this medication being used as a second line or subsequent therapy? Yes No

(if cervical carcinoma) Does the patient have PD-L1 positive disease? Yes No

(if bone cancer, non-pNET or NSCLC [1st line]) Is/Will the requested drug be(ing) used in combination with Yervoy (ipilimumab)? Yes No

(if anal cell carcinoma, non-pNET or NSCLC [1st line or subsequent]) Does the patient have metastatic disease? Yes No

(if NSCLC, 1st line) Is this medication being used as first-line therapy? Yes No

(if NSCLC, 1st line) Does the patient have PD-L1 expressing (greater than 1%) tumors? Yes No

(if NSCLC, 1st line) Does the patient have presence of EGFR (epidermal growth factor receptor) or ALK (anaplastic lymphoma kinase) genomic tumor aberrations? Yes No

(if NSCLC, neoadjuvant) Does the patient have resectable disease? Yes No

(if NSCLC, neoadjuvant) What is the patient's stage of disease?

- Occult (hidden) cancer
- Stage 0
- Stage 1 (includes: IA1, IA2, IA3, IB)
- Stage 2A (IIA)
- Stage 2B (IIB)
- Stage 3A (IIIA)
- Stage 3B (IIIB)
- Stage 3C (IIIC)
- Stage 4A (IVA)
- Stage 4B (IVB)

(if NSCLC, neoadjuvant) Is/Will the medication be(ing) given with platinum therapy (carboplatin, cisplatin)? Yes No

(if NSCLC, neoadjuvant, Stage 3B (IIIB)) Is/Will the medication be(ing) given with platinum-doublet chemotherapy? Yes No

(if NSCLC, neoadjuvant, Stage 3B (IIIB)) Will the patient receive Opdivo monotherapy as adjuvant therapy after surgery? Yes No

(if NSCLC, neoadjuvant, Stage 3B (IIIB)) Is the patient previously untreated? Yes No

(if NSCLC, neoadjuvant, Stage 3B (IIIB)) Does the patient have known EGFR (epidermal growth factor receptor) mutations or ALK (anaplastic lymphoma kinase) rearrangements? Yes No

(if NSCLC, subsequent therapy) Does the patient have performance status 0-2? Yes No

(if NSCLC, subsequent) Was the patient previously treated with platinum-base chemotherapy, such as carboplatin or cisplatin? Yes No

(if no) Which of the following applies to the patient?

- ALK-positive disease
- EGFR mutation-positive disease
- testing did not indicate either EGFR mutation- or ALK- positive disease
- molecular testing was not done

(if ALK-pos) Was the patient previously treated with Xalkori or Zykadia?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if EGFR mutation-pos) Was the patient previously treated with Gilotrif, Iressa, or Tarceva (erlotinib)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if pancreatic adenocarcinoma) Will the patient be using Opdivo in combination with Yervoy (ipilimumab)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if pancreatic adenocarcinoma) Is this medication being used as a second line or subsequent therapy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if pancreatic adenocarcinoma) Has the patient received prior immunotherapy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if pancreatic adenocarcinoma) Does the patient have tumor mutational burden-high (TMB-H) disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if pancreatic adenocarcinoma) Does the patient have locally advanced or metastatic disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if pancreatic adenocarcinoma) Does the patient have good performance status?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if pancreatic adenocarcinoma) Did the patient have disease progression?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if PMLBCL) Is this medication being used as a single-agent?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if PMLBCL) Will the patient receive therapy with brentuximab vedotin concurrently?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if EGFR mutation-pos) Was the patient previously treated with Gilotrif, Iressa, or Tarceva (erlotinib)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if SBA) Does the patient have advanced or metastatic disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if SBA) Which of the following best describes how the requested drug will be given to this patient?	
<input type="checkbox"/> as single agent therapy	
<input type="checkbox"/> in combination with Yervoy (ipilimumab)	
<input type="checkbox"/> neither of the above/unknown	
(if SCCHN) Did the patient have disease progression on or after platinum-containing chemotherapy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if RCC) Does the patient have advanced, stage IV, or relapsed disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if RCC) Will the drug requested be used in combination with Yervoy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if yes) Has the patient received any other chemotherapy before for this diagnosis?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if RCC, not in combo with Yervoy) Will the drug requested be used in combination with Cabometyx?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if RCC, with Cabometyx) Is this the first therapy the patient has received for this diagnosis?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if RCC, not in combo with Yervoy or Cabometyx) Has the patient previously received anti-angiogenic therapy (for example: Afinitor, Avastin, Inlyta, Nexavar, Sutent, Votrient)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if squamous vulvar) Does the patient have HPV-related advanced, recurrent or metastatic disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if anal cell carcinoma, cervical carcinoma, CRC, endometrial, GTN, HL, NSCLC [not in combo with Yervoy], SCCHN, squamous cell vulvar or RCC) Is the drug requested being used as single-agent therapy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if SCLC) Was the patient previously treated with platinum-based chemotherapy (such as carboplatin or cisplatin) AND at least one other line of therapy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if yes) Did the patient have progression of disease after these treatments?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if UCC/TCC) Which of these best describes the use of the requested medication?	
<input type="checkbox"/> As adjuvant treatment in patient at high risk of recurrence after undergoing radical resection	
<input type="checkbox"/> As first line treatment	
<input type="checkbox"/> For locally advanced or metastatic disease	
<input type="checkbox"/> None of the above	
(if UCC/TCC and locally advanced or metastatic) Was the patient previously treated with platinum-base chemotherapy, such as carboplatin or cisplatin?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if yes) Did the patient have progression of disease while on the drug or afterwards?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if UCC/TCC, and first line treatment) Will this medication be used in combination with cisplatin and gemcitabine?	Yes <input type="checkbox"/> No <input type="checkbox"/>
(if UCC/TCC, and first line treatment) Does the patient have metastatic or unresectable disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>

- (if biliary tract carcinoma) Has the patient previously been treated with any therapy for this diagnosis? Yes No
- (if biliary tract carcinoma) Has the patient previously been treated with any systemic therapy for this diagnosis? Yes No
- (if biliary tract carcinoma) Is this medication being used as a single agent? Yes No
- (if biliary tract carcinoma) Will the patient be using Opdivo in combination with ipilimumab (generic for Yervoy)? Yes No
- (if biliary tract carcinoma) Was the patient previously treated with a checkpoint inhibitor? Yes No
- (if biliary tract carcinoma) Does the patient have tumor mutation burden-high (TMB-H) tumors? Yes No
- (if biliary tract carcinoma) Did the patient have progression of disease during or after previous systemic treatments? Yes No
- (if biliary tract carcinoma) Does the patient have unresectable, resected gross residual disease, or metastatic disease? Yes No
- (if Kaposi sarcoma) Does the patient have relapsed OR refractory disease? Yes No
- (if Kaposi sarcoma) Does the patient have advanced cutaneous, oral, visceral, or nodal disease? Yes No
- (if Kaposi sarcoma) Did the patient have disease progression while on, or did not respond to, first line systemic therapy? Yes No
- (if Kaposi sarcoma) Will the patient be using Opdivo in combination with ipilimumab (generic for Yervoy)? Yes No
- (if anaplastic thyroid) Is this medication being used as a single-agent? Yes No
- (if anaplastic thyroid) Does the patient have stage IVC (metastatic) disease? Yes No
- (if anaplastic thyroid) How will this drug be used?
 As aggressive first-line therapy
 As second-line therapy
 None of the above

****This drug requires supportive documentation (i.e. genetic testing, chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.**

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

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