



## Yervoy

### 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](mailto: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

*Please indicate the place of service for the requested drug:*

- Ambulatory Surgical       Home       Off Campus Outpatient Hospital  
 On Campus Outpatient Hospital       Office       Pharmacy

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. CFT SOC Yervoy SGM 1796-A – 02/2023.

**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. Indicate the site of service requested:
- |   |  |
|---|--|
| <input type="checkbox"/> On Campus Outpatient Hospital                          | <input type="checkbox"/> Off Campus Outpatient Hospital                      |
| <input type="checkbox"/> Home infusion, <i>skip to Criteria Questions</i>       | <input type="checkbox"/> Physician office, <i>skip to Criteria Questions</i> |
| <input type="checkbox"/> Ambulatory surgical, <i>skip to Criteria Questions</i> | <input type="checkbox"/> Pharmacy, <i>skip to Criteria Questions.</i>        |
- B. Is this request to continue previously established treatment with the requested medication?
- No – This is a new therapy request (patient has not received 6 months or more of requested medication). *Skip to Clinical Criteria Questions*
- Yes – This is a continuation of existing treatment (patient has received requested medication for 6 months). *Skip to Clinical Criteria Questions*
- Yes – This is a continuation of an existing treatment (patient has received requested medication for 7 months or greater – initial 6 months plus 45 days grace period).
- C. Is the patient receiving provider administered combination chemotherapy? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***  Yes, *skip to Clinical Criteria Questions*  No
- D. 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
- E. 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
- F. 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
- G. 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
- H. 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  No

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. CFT SOC Yervoy SGM 1796-A – 02/2023.

**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**

**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 #200*

No, *Continue to #2*

2. What is the patient's diagnosis?

Cutaneous melanoma, *Continue to #10*

Uveal melanoma, *Continue to #20*

Central nervous system (CNS) brain metastases in patients with melanoma, *Continue to #30*

Non-small cell lung cancer, *Continue to #50*

Renal cell carcinoma, *Continue to #70*

Colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma), *Continue to #80*

Malignant pleural or peritoneal mesothelioma (including pericardial mesothelioma and tunica vaginalis testis mesothelioma), *Continue to #90*

Hepatocellular carcinoma, *Continue to #100*

Small bowel adenocarcinoma, *Continue to #110*

Ampullary adenocarcinoma, *Continue to #120*

Esophageal cancer, *Continue to #130*

Kaposi sarcoma, *Continue to #140*

Other, *No Further Questions*

**Cutaneous melanoma**

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

Adjuvant treatment, *Continue to #11*

Unresectable disease, *Continue to #15*

Metastatic disease, *Continue to #15*

Limited resectable local recurrence, *Continue to #13*

Other, *No Further Questions*

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

Stage III disease, *Continue to #12*

Stage IV disease, *Continue to #12*

Other, *Continue to #12*

12. Has the patient had a complete resection or no evidence of disease?

Yes, *Continue to #14*

No, *Continue to #14*

13. Has the patient received prior treatment with anti-PD-1 therapy?

Yes, *Continue to #14*

No, *Continue to #14*

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. CFT SOC Yervoy SGM 1796-A – 02/2023.

**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**

14. Will the requested drug be used as a single agent?

- Yes, *No Further Questions*  
 No, *No Further Questions*

15. Has the patient had disease progression on single-agent anti-programmed death 1 (PD-1) immunotherapy?

- Yes, *Continue to #16*  
 No, *Continue to #18*

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

- First-line therapy, *Continue to #17*  
 Subsequent therapy, *Continue to #17*

17. Will the requested drug be used in combination with pembrolizumab?

- Yes, *No Further Questions*  
 No, *No Further Questions*

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

- Single agent, *Continue to #19*  
 In combination with nivolumab, *Continue to #19*  
 Other, *Continue to #19*

19. How many doses of the requested drug will be given?

\_\_\_\_\_ doses, *No Further Questions*

*Uveal melanoma*

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

- Distant metastatic disease, *Continue to #21*  
 Other, *Continue to #21*

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

- Single agent, *No Further Questions*  
 In combination with nivolumab, *No Further Questions*  
 Other, *No Further Questions*

*Central nervous system (CNS) brain metastases in patients with melanoma*

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

- Single agent, *No Further Questions*  
 In combination with nivolumab, *No Further Questions*  
 Other, *No Further Questions*

*Non-small cell lung cancer*

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

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. CFT SOC Yervoy SGM 1796-A – 02/2023.

**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**

- In a regimen containing nivolumab, *Continue to #51*
- Other, *Continue to #51*

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

- Recurrent disease, *Continue to #52*
- Metastatic disease, *Continue to #52*
- Advanced disease, *Continue to #52*
- Other, *Continue to #52*

52. Are there no EGFR exon 19 deletions or L858R mutations or ALK rearrangements? **ACTION REQUIRED: Please attach documentation of EGFR exon 19 deletions or L858R mutations and ALK rearrangements, where applicable.**

- Yes, *No Further Questions*
- No, *Continue to #53*
- Unknown, *Continue to #53*

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

- Yes, *No Further Questions*
- No, *No Further Questions*

Renal cell carcinoma

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

- Relapsed disease, *Continue to #71*
- Advanced disease, *Continue to #71*
- Stage IV disease, *Continue to #71*
- Other, *Continue to #71*

71. Will the requested drug be used in combination with nivolumab?

- Yes, *Continue to #72*
- No, *Continue to #72*

72. How many doses of the requested drug will be given?

\_\_\_\_\_ doses, *Continue to #73*

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

- First-line treatment, *Continue to #74*
- Subsequent treatment, *Continue to #76*

74. Which of the following describes the risk?

- Poor risk, *No Further Questions*
- Intermediate risk, *No Further Questions*
- Favorable risk, *Continue to #75*

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. CFT SOC Yervoy SGM 1796-A – 02/2023.

**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**

75. What is the histology?

- Clear cell, *No Further Questions*
- Non-clear cell, *No Further Questions*

76. What is the histology?

- Clear cell, *No Further Questions*
- Non-clear cell, *No Further Questions*

Colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma)

80. Is the tumor microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)? ***ACTION REQUIRED: If 'Yes', attach laboratory report confirming microsatellite instability-high or mismatch repair deficient tumor status.***

- Yes, *Continue to #81*
- No, *Continue to #81*
- Unknown, *Continue to #81*

81. Will the requested drug be used in combination with nivolumab?

- Yes, *Continue to #82*
- No, *Continue to #82*

82. How many doses of the requested drug will be given?

\_\_\_\_\_ doses, *Continue to #83*

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

- Advanced disease, *No Further Questions*
- Metastatic disease, *No Further Questions*
- Unresectable disease, *No Further Questions*
- Inoperable disease, *No Further Questions*
- Other, *No Further Questions*

Malignant pleural or peritoneal mesothelioma, including pericardial mesothelioma and tunica vaginalis testis mesothelioma

90. Will the requested drug be used in combination with nivolumab?

- Yes, *No Further Questions*
- No, *No Further Questions*

Hepatocellular carcinoma

100. Will the requested drug be used in combination with nivolumab?

- Yes, *Continue to #101*
- No, *Continue to #101*

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

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. CFT SOC Yervoy SGM 1796-A – 02/2023.

**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**

- Initial treatment, *Continue to #102*
- Subsequent treatment, *Continue to #102*

102. How many doses of the requested drug will be given?  
\_\_\_\_\_ doses, *No Further Questions*

*Small bowel adenocarcinoma*

110. Will the requested drug be used in combination with nivolumab?

- Yes, *Continue to #111*
- No, *Continue to #111*

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

- Advanced disease, *Continue to #112*
- Metastatic disease, *Continue to #112*
- Other, *Continue to #112*

112. Is the tumor microsatellite-instability high (MSI-H) or mismatch repair deficient (dMMR)? ***ACTION REQUIRED: If 'Yes', attach laboratory report confirming microsatellite instability-high or mismatch repair deficient tumor status.***

- Yes, *No Further Questions*
- No, *No Further Questions*
- Unknown, *No Further Questions*

*Ampullary adenocarcinoma*

120. Will the requested drug be used in combination with nivolumab?

- Yes, *Continue to #121*
- No, *Continue to #121*

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

- Progressive disease, *Continue to #122*
- Unresectable disease, *Continue to #122*
- Metastatic disease, *Continue to #122*
- Other, *Continue to #122*

122. Is the tumor microsatellite-instability high (MSI-H) or mismatch repair deficient (dMMR)? ***ACTION REQUIRED: If 'Yes', attach laboratory report confirming microsatellite instability-high or mismatch repair deficient tumor status.***

- Yes, *No Further Questions*
- No, *No Further Questions*
- Unknown, *No Further Questions*

*Esophageal cancer*

130. What is the patient's histology?

- Squamous cell carcinoma, *Continue to #131*

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. CFT SOC Yervoy SGM 1796-A – 02/2023.

**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**

Other, *Continue to #131*

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

Unresectable advanced disease, *Continue to #132*

Metastatic disease, *Continue to #132*

Other, *Continue to #132*

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

First-line treatment, *Continue to #133*

Subsequent treatment, *Continue to #133*

133. Will the requested drug be used in combination with nivolumab?

Yes, *No Further Questions*

No, *No Further Questions*

*Kaposi Sarcoma*

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

Yes, *Continue to #141*

No, *Continue to #141*

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

First-line therapy, *Continue to #142*

Subsequent treatment, *Continue to #142*

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

Relapsed/refractory disease, *No further questions*

Other, *No further questions*

*Continuation of therapy*

200. What is the patient's diagnosis?

Cutaneous melanoma, *Continue to #201*

Uveal melanoma, *Continue to #230*

Central nervous system (CNS) brain metastases in patients with melanoma, *Continue to #230*

Non-small cell lung cancer, *Continue to #220*

Renal cell carcinoma, *Continue to #210*

Colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma), *Continue to #210*

Malignant pleural or peritoneal mesothelioma (including pericardial mesothelioma and tunica vaginalis testis mesothelioma), *Continue to #220*

Hepatocellular carcinoma, *Continue to #210*

Small bowel adenocarcinoma, *Continue to #230*

Ampullary adenocarcinoma, *Continue to #230*

Esophageal cancer, *Continue to #220*

Kaposi sarcoma, *Continue to #230*

Other, *No Further Questions*

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. CFT SOC Yervoy SGM 1796-A – 02/2023.

**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**



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

- Yes, *Continue to #202*  
 No, *Continue to #210*

202. Is there evidence of disease progression or unacceptable toxicity on the current regimen?

- Yes, *Continue to #203*  
 No, *Continue to #203*

203. How many months of adjuvant treatment has the patient received with the requested drug?

\_\_\_\_\_ Months, *No Further Questions*

*Continuation of therapy – cutaneous melanoma, renal cell carcinoma, colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma), hepatocellular carcinoma*

210. Is there evidence of disease progression or unacceptable toxicity on the current regimen?

- Yes, *Continue to #211*  
 No, *Continue to #211*

211. How many doses of the requested drug has the patient already received?

\_\_\_\_\_ doses, *No Further Questions*

*Continuation of therapy – non-small cell lung cancer, esophageal cancer, or malignant pleural or peritoneal mesothelioma, including pericardial mesothelioma and tunica vaginalis testis mesothelioma*

220. Is there evidence of disease progression or unacceptable toxicity on the current regimen?

- Yes, *Continue to #221*  
 No, *Continue to #221*

221. How many continuous months of treatment has the patient received with the requested drug?

\_\_\_\_\_ Months, *No Further Questions*

*Continuation of therapy – other indications*

230. 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)**

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. CFT SOC Yervoy SGM 1796-A – 02/2023.

**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**