



Please complete ALL information below and fax your request to 1-888-671-5285

### Yervoy® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Colorectal cancer					
<input type="checkbox"/> Melanoma					
<input type="checkbox"/> Renal cell carcinoma					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Prescriber's Specialty:</b>					
Is Yervoy prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>For colorectal cancer, answer the following:</b>					
Does the patient have microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer (CRC)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if the patient has experienced disease progression following treatment with the following:					
<input type="checkbox"/> Fluoropyrimidine					
<input type="checkbox"/> Oxaliplatin					
<input type="checkbox"/> Irinotecan					
Will the patient use Yervoy in combination with Opdivo (nivolumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>For melanoma, answer the following:</b>					
Does the patient have unresectable or metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have cutaneous melanoma? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have pathologic involvement of regional lymph nodes of more than 1 millimeter? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient undergone resection, including total lymphadenectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>For renal cell carcinoma, answer the following:</b>					
Does the patient have advanced, relapsed, or stage IV disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have surgically unresectable disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have intermediate- or poor-prognosis risk? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have previously untreated disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will Yervoy be used in combination with Opdivo (nivolumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Reauthorization:</b>					
Does the patient show evidence of progressive disease while on Yervoy therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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Office use only: Yervoy\_FSP\_2018Dec-W



## Yervoy<sup>®</sup> Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.