FUTURE SCRIPTS

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:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

- ❑ Colorectal cancer
- ❑ Melanoma
- ❑ Renal cell carcinoma
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Is Yervoy prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**

For colorectal cancer, answer the following:

Does the patient have microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer (CRC)? ❑ **Yes** ❑ **No**

Does the patient have metastatic disease? ❑ **Yes** ❑ **No**

Select if the patient has experienced disease progression following treatment with the following:

- ❑ Fluoropyrimidine
- ❑ Oxaliplatin
- ❑ Irinotecan

Will the patient use Yervoy in combination with Opdivo (nivolumab)? ❑ **Yes** ❑ **No**

For melanoma, answer the following:

Does the patient have unresectable or metastatic disease? ❑ **Yes** ❑ **No**

Does the patient have cutaneous melanoma? ❑ **Yes** ❑ **No**

Does the patient have pathologic involvement of regional lymph nodes of more than 1 millimeter? ❑ **Yes** ❑ **No**

Has the patient undergone resection, including total lymphadenectomy? ❑ **Yes** ❑ **No**

For renal cell carcinoma, answer the following:

Does the patient have advanced, relapsed, or stage IV disease? ❑ **Yes** ❑ **No**

Does the patient have surgically unresectable disease? ❑ **Yes** ❑ **No**

Does the patient have intermediate- or poor-prognosis risk? ❑ **Yes** ❑ **No**

Does the patient have previously untreated disease? ❑ **Yes** ❑ **No**

Will Yervoy be used in combination with Opdivo (nivolumab)? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient show evidence of progressive disease while on Yervoy therapy? ❑ **Yes** ❑ **No**

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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?

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