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

Opdivo
(nivolumab)

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:
☐ Standard ☐ 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: ☐ Opdivo 40mg vial ☐ Opdivo 100mg vial ☐ Opdivo 120 mg vial ☐ Opdivo 240mg vial

Directions for use: Quantity: Duration of therapy: J-Code:

ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***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 ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

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? ☐ Yes ☐ No

Diagnosis related to use:
☐ ampullary adenocarcinoma
☐ anal cell carcinoma
☐ anaplastic thyroid carcinoma
☐ biliary tract carcinoma
☐ bone cancer (including chondrosarcoma, chordoma, Ewing sarcoma, and osteosarcoma)
☐ brain metastases
☐ cervical carcinoma
☐ chronic lymphocytic leukemia/small lymphocytic lymphoma for histologic (Richter's) transformation to diffuse large B-cell lymphoma
☐ colorectal cancer (CRC)
☐ endometrial carcinoma
☐ esophageal adenocarcinoma
☐ esophageal squamous cell carcinoma (ESCC)
☐ esophageal cancer
☐ extranodal NK/T-cell lymphoma, nasal type
☐ gastric cancer
☐ gastroesophageal junction (GEJ) cancer
☐ gestational trophoblastic neoplasia (GTN)
☐ hepatocellular carcinoma (HCC)
☐ Hodgkin lymphoma (HL)
☐ 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 your 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 your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if nasopharyngeal carcinoma) Per the information provided above, which of the following is true for your 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 your patient responding to therapy OR is your 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 your patient previously treated with only one other chemotherapy regimen for this diagnosis? Yes ☐ No ☐

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

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

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

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

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

(if yes) Did your 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 your patient have recurrent disease? Yes ☐ No ☐

(if CRC) Does your patient have unresectable, advanced, or metastatic disease? Yes ☐ No ☐
(if CRC or SBA) Has your patient undergone immunohistochemistry (IHC) or microsatellite instability (MSI) testing? Yes ☐ No ☐
(if yes) What were the results?
☐ deficient mismatch repair (dMMR) or microsatellite instability-high (MSI-H)
☐ proficient mismatch repair (pMMR) or microsatellite instability-low or stable (MSI-low or MSI-stable)

(if CLL/SLL) Does your patient have the del(17p)/TP53 mutation? Yes ☐ No ☐
(if no) Is your patient refractory to chemotherapy and unable to receive chemoimmunotherapy? Yes ☐ No ☐

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

(if yes) Will your 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 your 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) Was your patient treated with chemoradiation followed by surgery to remove the cancer, but some cancer cells were found in the removed tumor or lymph nodes? Yes ☐ No ☐

(if yes) Is this medication being given to help prevent the cancer from coming back? Yes ☐ No ☐

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

(if extranodal NK/T-cell lymphoma, nasal type) Was your patient previously treated with more than 1 regimen of chemotherapy? Yes ☐ No ☐
(if yes) Was one of the lines of therapy an alternate combination chemotherapy regimen (asparaginase-based) that was not previously used? Yes ☐ No ☐

(if GTN) Does your patient have recurrent or progressive disease? Yes ☐ No ☐
(if GTN) Was your patient previously treated with a platinum/etoposide-containing regimen? Yes ☐ No ☐

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

(if no Nexavar and HCC) Does your 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) Which type of Hodgkin lymphoma does your patient have?
☐ classical type
☐ nodular lymphocyte predominant type
☐ unknown
(if HL) Which of the following applies to your patient?
☐ relapsed or refractory disease
☐ palliative therapy and patient is older than 60 years
☐ neither of the above
(if relapsed/refractory) Has your patient undergone an autologous stem cell transplant? Yes ☐ No ☐
(if yes) After the transplant, did your 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 your patient have metastatic or unresectable disease? Yes ☐ No ☐

(if melanoma & adjuvant tx) Did your 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 your 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 your patient have PD-L1 expressing (greater than 1%) tumors? Yes ☐ No ☐

(if NSCLC, 1st line) Does your 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 your patient have known EGFR (epidermal growth factor receptor) mutations or ALK (anaplastic lymphoma kinase) rearrangements? Yes ☐ No ☐

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

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

(if no) Which of the following applies to your 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 your patient previously treated with Xalkori or Zykadia? Yes ☐ No ☐

(if EGFR mutation-pos) Was your patient previously treated with Gilotrif, Iressa, or Tarceva (erlotinib)? Yes ☐ No ☐

(if pancreatic adenocarcinoma) Will your patient be using Opdivo in combination with Yervoy (ipilimumab)? Yes ☐ No ☐

(if pancreatic adenocarcinoma) Is this medication being used as a second line or subsequent therapy? Yes ☐ No ☐

(if pancreatic adenocarcinoma) Has the patient received prior immunotherapy? Yes ☐ No ☐

(if pancreatic adenocarcinoma) Does your patient have tumor mutational burden-high (TMB-H) disease? Yes ☐ No ☐

(if pancreatic adenocarcinoma) Does your patient have locally advanced or metastatic disease? Yes ☐ No ☐

(if pancreatic adenocarcinoma) Does the patient have good performance status? Yes ☐ No ☐

(if pancreatic adenocarcinoma) Did your patient have disease progression? Yes ☐ No ☐

(if PMLBCL) Which of the following best describes how the requested drug will be given to this patient?
☐ single agent therapy
☐ given with Adcetris (brentuximab vedotin)
☐ neither of the above/unknown

(if EGFR mutation-pos) Was your patient previously treated with Gilotrif, Iressa, or Tarceva (erlotinib)? Yes ☐ No ☐

(if SBA) Does your patient have advanced or metastatic disease? Yes ☐ No ☐
(if SBA) Which of the following best describes how the requested drug will be given to this patient?
☐ as single agent therapy
☐ in combination with Yervoy (ipilimumab)
☐ neither of the above/unknown

(if SCCHN) Was your patient previously treated with platinum-base chemotherapy, such as carboplatin or cisplatin? Yes ☐ No ☐
(if yes) Did your patient have progression of disease afterwards? Yes ☐ No ☐
Please provide the following details: drug name, date(s) taken and for how long, and what the documented results were of taking each drug.

(if RCC) Does your patient have advanced, stage IV, or relapsed disease? Yes ☐ No ☐
(if RCC) Will the drug requested be used in combination with Yervoy? Yes ☐ No ☐
(if yes) Has your patient received any other chemotherapy before for this diagnosis? Yes ☐ No ☐
(if RCC, not in combo with Yervoy) Will the drug requested be used in combination with Cabometyx? Yes ☐ No ☐
(if RCC, with Cabometyx) Is this the first therapy your patient has received for this diagnosis? Yes ☐ No ☐
(if RCC, not in combo with Yervoy or Cabometyx) Has your patient previously received anti-angiogenic therapy (for example: Afinitor, Avastin, Inlyta, Nexavar, Sutent, Votrient? Yes ☐ No ☐
(if squamous vulvar) Does your patient have HPV-related advanced, recurrent or metastatic disease? Yes ☐ No ☐

(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 ☐ No ☐

(if SCLC) Was your patient previously treated with platinum-based chemotherapy (such as carboplatin or cisplatin) AND a least one other line of therapy? Yes ☐ No ☐
(if yes) Did your patient have progression of disease after these treatments? Yes ☐ No ☐
Please provide the following details: drug name, date(s) taken and for how long, and what the documented results were of taking each drug.

(if UCC/TCC) Which of these best describes the use of the requested medication?
☐ As adjuvant treatment in patient at high risk of recurrence after undergoing radical resection
☐ As first line treatment
☐ For locally advanced or metastatic disease
☐ None of the above

(if UCC/TCC and locally advanced or metastatic) Was your patient previously treated with platinum-base chemotherapy, such as carboplatin or cisplatin? Yes ☐ No ☐
(if yes) Did your patient have progression of disease while on the drug or afterwards? Yes ☐ No ☐
(if UCC/TCC, and first line treatment) Will this medication be used in combination with cisplatin and gemcitabine? Yes ☐ No ☐
(if UCC/TCC, and first line treatment) Does the patient have metastatic or unresectable disease? Yes ☐ No ☐

(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 your patient be using Opdivo in combination with ipilimumab (generic for Yervoy)? Yes ☐ No ☐
(if biliary tract carcinoma) Was your patient previously treated with a checkpoint inhibitor? Yes ☐ No ☐
(if biliary tract carcinoma) Does your patient have tumor mutation burden-high (TMB-H) tumors? Yes ☐ No ☐
(if biliary tract carcinoma) Did your 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 your patient have relapsed OR refractory disease? Yes ☐ No ☐
(if Kaposi sarcoma) Does your patient have advanced cutaneous, oral, visceral, or nodal disease? Yes ☐ No ☐

(if Kaposi sarcoma) Did your patient have disease progression while on, or did not respond to, first line systemic therapy? Yes ☐ No ☐

(if Kaposi sarcoma) Will your 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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