Opdivo Qvantig
(nivolumab; hyaluronidase)

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:

☐ 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 Qvantig

Directions for use: Quantity: Duration of Therapy: J-code:

ICD10:

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ 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):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*
Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

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

What is your patient's diagnosis?

☐ ampullary adenocarcinoma
☐ anal cell carcinoma
☐ anaplastic thyroid carcinoma
☐ Biliary tract carcinoma
☐ brain metastases
☐ cervical carcinoma
☐ colorectal cancer (CRC)
☐ esophageal adenocarcinoma
☐ esophageal squamous cell carcinoma (ESCC)
☐ esophageal cancer
☐ gastric cancer
☐ gastroesophageal junction (GEJ) cancer
☐ gestational trophoblastic neoplasia (GTN)
☐ hepatocellular carcinoma (HCC)
☐ Kaposi sarcoma
☐ malignant pleural mesothelioma (MPM)
☐ melanoma
☐ Merkel cell carcinoma (MCC)
☐ non-pancreatic neuroendocrine tumor (non-pNET)
☐ non-small cell lung cancer (NSCLC)
☐ renal cell carcinoma (RCC)
☐ small bowel adenocarcinoma (SBA)
☐ small cell lung cancer (SCLC)
☐ squamous cell carcinoma of the head and neck (SCCHN)
☐ squamous cell vaginal carcinoma
☐ squamous cell vulvar carcinoma
☐ urothelial carcinoma (UCC, also transitional cell carcinoma, TCC)
☐ other

(if other) What is the diagnosis related to use?

Clinical Information:

*****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.**

Has the patient tried and cannot take Opdivo intravenous (IV) [may require prior authorization]? ☐ Yes ☐ No

(if no) Is the patient unable to obtain IV access? ☐ Yes ☐ No

(if anal cell carcinoma, non-pNET, squamous vaginal, 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 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 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 CRC) Has your patient's cancer progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan, as monotherapy or as monotherapy following combination treatment with intravenous nivolumab and ipilimumab? ☐ 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?
Notes: Examples of platinum therapy are carboplatin and cisplatin. Etopophos and Toposar are brand names of etoposide.
☐ Yes ☐ No

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

(if HCC) Has the patient previously had treatment with intravenous nivolumab and ipilimumab? ☐ Yes ☐ No

(if anal cell carcinoma, non-pNET) Does your patient have metastatic disease? ☐ Yes ☐ No

(if SCCHN) Was your patient previously treated with platinum-based 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 RCC) Does your patient have advanced stage IV or relapsed disease? ☐ Yes ☐ No

(if RCC) Will the drug requested be used in combination with Cabometyx? ☐ Yes ☐ No

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

(if RCC) Has your patient received any other chemotherapy before for this diagnosis? ☐ Yes ☐ No

(if RCC, if previous treatment) Will this drug be used as single agent therapy after previous treatment with anti-angiogenic therapy (that is, Afinitor, Avastin, Inlyta, Nexavar, Sutent, Votrient)? ☐ Yes ☐ No

(if RCC, if no previous treatment) Will the requested drug be used in a patient with intermediate or poor risk disease, as a first-line treatment following combination treatment with intravenous nivolumab and ipilimumab? ☐ Yes ☐ No

(if SCLC) Was your patient previously treated with platinum-based chemotherapy (such as carboplatin or cisplatin) AND at least one other line of therapy? ☐ Yes ☐ No

(if yes) Did your patient have progression of disease after these treatments? ☐ Yes ☐ No

(if squamous vaginal) Does your patient have advanced, recurrent, or metastatic disease? ☐ Yes ☐ No

(if squamous vulvar) Does your patient have HPV-related advanced, recurrent, or metastatic disease? ☐ Yes ☐ No

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

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

(if anal cell carcinoma, anaplastic thyroid carcinoma, cervical carcinoma, endometrial, GTN, SCCHN, squamous vaginal, squamous cell vulvar) Is the drug requested being used as single-agent therapy?
Notes: Single-agent therapy means no other chemotherapy is being used with Opdivo Qvantig (nivolumab hyaluronidase).
☐ Yes ☐ No

(if MPM) Which of the following applies?
Notes: Single-agent therapy means no other chemotherapy is being used with Opdivo.Qvantig
☐ The drug requested is/will be(ing) used as single-agent therapy
☐ other or unknown

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

(if yes) Will your patient be using Opdivo Qvantig in combination with fluoropyrimidine- and platinum-containing chemotherapy? ☐ Yes ☐ No

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

(if no) Does the patient have completely resected disease with residual pathologic disease AND has received neoadjuvant chemoradiotherapy (CRT)? ☐ Yes ☐ No

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

(if gastric, GEJ or esophageal adenocarcinoma) 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 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
- ☐ neither of the above/unknown

(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) 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 anaplastic thyroid) Does the patient have stage IVC (metastatic) disease? ☐ Yes ☐ No

(if anaplastic thyroid) How will this drug be used?
- ☐ aggressive first-line therapy
- ☐ second-line therapy
- ☐ neither of the above or unknown

(if NSCLC) Does the patient have resectable non-small cell lung cancer (NSCLC) (tumors at least 4 cm or node positive)? ☐ Yes ☐ No

(if NSCLC, resectable tumors) Does the patient have no known EGFR mutations or ALK rearrangements? ☐ Yes ☐ No

(if NSCLC, resectable tumors, if no known EGFR mutations or ALK rearrangements) Will this drug be used for neoadjuvant treatment, in combination with platinum-doublet chemotherapy, followed by OPDIVO QVANTIG monotherapy as adjuvant treatment after surgery? ☐ Yes ☐ No

(if NSCLC, resectable tumors) Will this drug be used in the neoadjuvant setting, in combination with platinum-doublet chemotherapy? ☐ Yes ☐ No

(if NSCLC, NO resectable tumors) Does the patient have metastatic disease and progression on or after platinum based chemotherapy? ☐ Yes ☐ No

(if NSCLC, NO resectable tumors) Does the patient have EGFR or ALK genomic tumor aberrations? ☐ Yes ☐ No

(if NSCLC, NO resectable tumors, with EGFR or ALK genomic tumor aberrations) Did the patient have disease progression on FDA-approved therapy for these aberrations prior to receiving OPDIVO QVANTIG? ☐ Yes ☐ No

(if UCC/TCC) Which of these best describes the use of the requested medication?
- ☐ As adjuvant treatment
- ☐ As first line treatment
- ☐ As subsequent therapy after patient had disease progression on another therapy
- ☐ None of the above or Unknown

(if adjuvant treatment) Will the requested drug be used as adjuvant treatment in patients at high risk of recurrence after undergoing radical resection? ☐ Yes ☐ No

(if first line treatment) Will the requested drug be used in combination with cisplatin and gemcitabine for metastatic or unresectable disease? ☐ Yes ☐ No

(if disease progression) Does your patient have locally advanced or metastatic disease with disease progression during or after platinum-containing chemotherapy (that is, carboplatin, cisplatin?) ☐ Yes ☐ No

(if no) Does your patient have locally advanced or metastatic disease with disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy? ☐ 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 completely resected Stage IIB, Stage IIC, Stage III, or Stage IV disease
☐ Single-agent therapy
☐ Following combination treatment with intravenous nivolumab and ipilimumab
☐ Other

(if melanoma, if adjuvant treatment for metastatic disease that has spread to the lymph nodes) Did your patient have complete resection of the melanoma? ☐ Yes ☐ No

(if melanoma, if single-agent therapy) Does your patient have metastatic or unresectable disease? ☐ Yes ☐ No

(if melanoma, if following combination treatment with intravenous nivolumab and ipilimumab) Does your patient have metastatic or unresectable disease? ☐ Yes ☐ No

Additional Pertinent Information: *Please provide clinical support for the use of this drug in your patient (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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