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

Yervoy
(ipilimumab)

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: ☐ Yervoy 50mg/10ml vial ☐ Yervoy 200mg/40ml vial

Is this a new start? Yes ☐ No ☐ Start date:

Dose: Frequency of therapy: Duration of therapy:

Will this medication be given concurrently with other agents? Yes ☐ No ☐
If yes, please specify:

What is your patient's current weight? ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Bristol-Myers Squibb Adjuvant Program
☐ 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 your 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
☐ biliary tract cancers (BTC)
☐ bone cancer (including chondrosarcoma, chordoma,Ewing Sarcoma, Osteosarcoma)
☐ colorectal cancer (CRC)
☐ esophageal squamous cell carcinoma (ESCC)
☐ gastric carcinoma
☐ gestational trophoblastic neoplasia
☐ hepatocellular carcinoma (HCC)
☐ kaposi sarcoma (KS)
☐ malignant pleural mesothelioma (MPM)
☐ melanoma without brain metastases

☐ melanoma with brain metastases
☐ melanoma with brain metastases
☐ non-pancreatic neuroendocrine tumors (non-pNET)
☐ non-small cell lung cancer (NSCLC)
☐ pancreatic adenocarcinoma
☐ pancreatic neuroendocrine tumors (pNET)
☐ renal cell carcinoma (RCC)
☐ small bowel adenocarcinoma
☐ small cell lung cancer (SCLC)
☐ soft tissue sarcomas (including Angiosarcoma, Extremity/Body Wall, Head/Neck, Retroperitoneal/Intra-Abdominal, and Rhabdomyosarcoma)
☐ squamous cell carcinoma of head/neck
☐ other (please specify):

Clinical Information

Is this new start or continuation of therapy? ☐ New start ☐ Continued therapy

****This drug requires supportive documentation (i.e. genetic testing, chart notes, pathology reports, lab/test results, etc). Supportive documentation for all answers must be attached with this request.****

(if melanoma) Which of the following applies to your patient?
☐ metastatic disease
☐ resected disease (adjuvant therapy)
☐ unresectable disease
☐ none of the above

(if resected or none of the above) Which of the following applies to your patient?
☐ cutaneous melanoma, including superficial spreading melanoma, nodular melanoma, lentigo maligna melanoma, or acral lentiginous melanoma
☐ mucosal melanoma or ocular melanoma, including uveal melanoma and choroidal melanoma
☐ other

(if cutaneous) Does your patient have Stage III disease? Yes ☐ No ☐

(if cutaneous) Does your patient have clinically node positive disease OR pathologic involvement of regional lymph nodes of more than 1 mm? Yes ☐ No ☐

(if cutaneous) Did your patient have complete resection of the primary melanoma (including any present in-transit or satellite metastasis with no distant metastasis) with adequate surgical margins? Yes ☐ No ☐

(if cutaneous) Did your patient have a total lymphadenectomy (lymph node dissection)? Yes ☐ No ☐

(if unresectable or metastatic melanoma) Which of the following best describes how the drug requested will be used?
☐ Being given as first line therapy with Opdivo
☐ Being given as subsequent therapy for disease progression AND the requested drug has NOT been previously used
☐ Being given as reinduction therapy
☐ none of the above

(if reinduction therapy) Is the drug requested being given as single-agent therapy? Notes: Single-agent therapy means no other chemotherapy will be used. Yes ☐ No ☐

(if reinduction therapy) Does your patient have history of significant systemic toxicity with previous Yervoy (ipilimumab) therapy? Yes ☐ No ☐

(if no) Did your patient relapse after an initial clinical response? Yes ☐ No ☐

(if no) Did your patient experience disease progression after having stable disease for more than 3 months? Yes ☐ No ☐

(if unresectable or metastatic melanoma or SCLC) Does your patient have performance status 0-2? Yes ☐ No ☐

(if SCLC) Has your patient previously received any type of therapy (before the drug requested) for the treatment of this disease? Yes ☐ No ☐

(if ESCC) Has your patient previously received any type of therapy (before the drug requested) for the treatment of this disease? Yes ☐ No ☐

(if ESCC, NSCLC or SCLC) Will your patient be using the drug requested with Opdivo? Yes ☐ No ☐

(if SCLC) Does your patient have primary progressive disease? Yes ☐ No ☐

(if no) Did your patient relapse within 6 months following complete or partial response or stable disease with initial treatment? Yes ☐ No ☐

(if brain mets) Is the drug requested being used as single-agent therapy OR in combination with Opdivo?
☐ Yes, as single-agent therapy
☐ Yes, in combination with Opdivo
☐ No

(if brain mets) Does your patient have recurrent disease? Yes ☐ No ☐

(if RCC) Does your patient have advanced stage IV or relapsed disease? Yes ☐ No ☐

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

(if HCC, MPM, RCC) Will the drug requested be used in combination with Opdivo? Yes ☐ No ☐

(if MPM) Has your patient previously used any type of systemic therapy for this diagnosis? Yes ☐ No ☐

(if NSCLC) Does your patient have tumor mutational burden (TMB)? Yes ☐ No ☐

(if no TMB) Is the drug requested the first type of treatment your patient has received for this diagnosis? Yes ☐ No ☐

(if not high TMB) Does your patient have metastatic disease? Yes ☐ No ☐

(if not high TMB) Does your patient have PD-L1 expressing (greater than 1%) tumors? Yes ☐ No ☐

(if not high TMB) 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 CRC or small bowel adenocarcinoma) Will the requested drug be taken in combination with Opdivo (nivolumab)? Yes ☐ No ☐

(if CRC, non-pancreatic neuroendocrine tumors [NET]) Does your patient have metastatic disease? Yes ☐ No ☐

(if CRC or small bowel adenocarcinoma) 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 HCC) Has your patient been previously treated with sorafenib (Nexavar)? Yes ☐ No ☐

(if HCC, no sorafenib) Does the patient have unresectable or metastatic disease? Yes ☐ No ☐

(if unresectable or metastatic HCC) Has your patient previously received any type of therapy (before this medication) for the treatment of this disease? Yes ☐ No ☐

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

(if non-pancreatic neuroendocrine tumors [NET]) Did your patient have disease progression on first line chemotherapy? Yes ☐ No ☐

(if bone cancer) Does the patient have metastatic or unresectable disease? Yes ☐ No ☐

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

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

(if yes) Did the 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 gastric carcinoma) Has your patient previously received any type of therapy (before this medication) for the treatment of this disease? Yes ☐ No ☐

(if gastric carcinoma) Has your patient undergone immunohistochemistry (IHC) or microsatellite instability (MSI) testing? Yes ☐ No ☐

(if gastric carcinoma and undergone IHC or MSI testing) 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 ampullary adenocarcinoma, bone cancer, BTC, gastric carcinoma, Kaposi Sarcoma, non-pancreatic neuroendocrine tumors [NET], Pancreatic adenocarcinoma, Soft Tissue Sarcomas) Will the drug requested be used in combination with Opdivo (nivolumab)? Yes ☐ No ☐

(if KS) Has your patient previously used any type of therapy for this diagnosis? Yes ☐ No ☐

(if KS) Does your patient have relapsed/refractory advanced cutaneous, oral, visceral, or nodal disease? Yes ☐ No ☐

(if KS) Which of the following best describes your patient's disease progression with prior therapy?
☐ cancer progressed on first-line systemic therapy
☐ cancer did not respond to first-line systemic therapy
☐ None of the above

(if KS) Did the patient's cancer progress on alternate first-line systemic therapy? Yes ☐ No ☐

(if Pancreatic adenocarcinoma) Has your patient previously used any type of therapy for this diagnosis? Yes ☐ No ☐

(if Pancreatic adenocarcinoma) Has your patient previously used any immunotherapy for this diagnosis? Yes ☐ No ☐

(if Pancreatic adenocarcinoma) Does your patient have a high tumor mutational burden (TMB-H) of at least 10 mut/Mb? Yes ☐ No ☐

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

(if Pancreatic adenocarcinoma) Does your patient have good performance status? Yes ☐ No ☐

(if yes) Does your patient have disease progression? Yes ☐ No ☐

(if BTC) Has your patient previously received any type of therapy (before this medication) for the treatment of Biliary Tract Cancers (BTC)? Yes ☐ No ☐

(if BTC, no previous therapy) Does the patient have unresectable, resected gross residual disease or metastatic disease that is tumor mutational burden-high (TMB-H)? Yes ☐ No ☐

(if BTC, previous therapy) Does your patient have disease progression while on systemic treatment or after systemic treatment? Yes ☐ No ☐

(if BTC, disease progression) Does the patient have unresectable, resected gross residual disease or metastatic disease? Yes ☐ No ☐

(if BTC, unresectable, resected gross residual or metastatic disease) Does the patient have disease that is tumor mutational burden-high (TMB-H)? Yes ☐ No ☐

(if BTC, TMB-H) Was your patient previously treated with a checkpoint inhibitor? Yes ☐ No ☐

(if gestational trophoblastic neoplasia) Does the patient have recurrent or progressive disease? Yes ☐ No ☐

(if gestational trophoblastic neoplasia) Has the patient been treated with a platinum/etoposide-containing chemotherapy regimen for this diagnosis before? Yes ☐ No ☐

(if squamous cell carcinoma of head/neck) Has the patient experienced disease progression on or after platinum-containing chemotherapy? Yes ☐ No ☐

(if gestational trophoblastic neoplasia or squamous cell carcinoma of head/neck) Is this medication being given as single agent therapy? Yes ☐ No ☐

Additional Pertinent Information: *(including prior therapy, disease stage, 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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