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 240mg vial

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

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):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 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:
☐ anal cell carcinoma
☐ brain metastases
☐ 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 small cell carcinoma
☐ esophageal squamous cell carcinoma (ESCC)
☐ extranodal NK/T-cell lymphoma, nasal type
☐ gastric cancer
☐ gastroesophageal junction (GEJ) cancer
☐ gestational trophoblastic neoplasia (GTN)
☐ hepatocellular carcinoma (HCC)
☐ Hodgkin lymphoma (HL)
☐ malignant pleural mesothelioma (MPM)
☐ melanoma
☐ Merkel cell carcinoma (MCC)
☐ Non-pancreatic neuroendocrine tumor (non-pNET)
☐ non-small cell lung cancer (NSCLC)
☐ primary mediastinal large B-cell lymphoma (PMLBCL)

☐ renal cell carcinoma (RCC)
☐ small bowel adenocarcinoma (SBA)
☐ small cell lung cancer (SCLC)
☐ squamous cell carcinoma of the head and neck (SCCHN)
☐ squamous cell vulvar carcinoma
☐ urothelial carcinoma (UCC, also transitional cell carcinoma [TCC])
☐ other *(please specify):*

Clinical Information

Is this new start or continuation of therapy? ☐ new start ☐ continued therapy

(if continued 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 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 CRC) Has your patient previously used any type of chemotherapy for this diagnosis? Yes ☐ No ☐

(if no previous chemo) Is intensive therapy appropriate for your patient? Yes ☐ No ☐

(if previous chemo) Has your patient been previously treated with an oxaliplatin-based chemotherapy regimen? Yes ☐ No ☐

(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) Does your patient have unresectable advanced or metastatic disease? Yes ☐ No ☐

(if ESCC) Has your patient previously been treated with fluoropyrimidine and platinum based chemotherapy for this diagnosis? 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 any type of esophageal OR GEJ cancer) 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? 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) Is the drug requested being used as adjuvant treatment? Yes ☐ No ☐

(if melanoma & and not adjuvant) Does your patient have metastatic or unresectable disease? Yes ☐ No ☐
(if melanoma & adjuvant tx) Does your patient have metastatic disease? Yes ☐ No ☐
(if melanoma & adjuvant tx) Has your patient's disease spread to the lymph nodes? Yes ☐ No ☐
(if melanoma & adjuvant tx) Did your patient have complete resection of the melanoma? Yes ☐ No ☐

(if melanoma [not adjuvant] or 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 non-pNET or NSCLC) Is/Will the requested drug be(ing) used in combination with Yervoy (ipilimumab)? Yes ☐ No ☐
(if anal cell carcinoma, non-pNET or NSCLC) Does your patient have metastatic disease? Yes ☐ No ☐
(if NSCLC and not with Yervoy) Does your patient have performance status 0-2? Yes ☐ No ☐

(if NSCLC and not with Yervoy) 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? Yes ☐ No ☐

(if NSCLC with Yervoy) Is the drug requested the first type of treatment your patient has received for this diagnosis? Yes ☐ No ☐
(if NSCLC with Yervoy) Does your patient have PD-L1 expressing (greater than 1%) tumors? 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 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 any of the following: 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, 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) Does your patient have locally advanced or metastatic disease? Yes ☐ No ☐
(if UCC/TCC) 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 ☐
Please provide the following details: drug name, date(s) taken and for how long, and what the documented results were of taking each drug.

****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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