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 (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 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:
☐ colorectal cancer (CRC)
☐ hepatocellular carcinoma (HCC)
☐ 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 neuroendocrine tumors (pNET)
☐ renal cell carcinoma (RCC)
☐ small bowel adenocarcinoma
☐ small cell lung cancer (SCLC)
☐ other (please specify):

Clinical Information

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

How many treatment doses are being requested?

(if continued therapy) How many doses has your patient already received? Please include dates of 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 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 melanoma) Which of the following applies to your patient?

- ☐ metastatic disease
- ☐ resected disease (adjuvant therapy)***
- ☐ unresectable disease
- ☐ none of the above***

*****Supportive documentation, including pathology reports, must be included.*****

(if resected/adjuvant 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 (please specify:)

(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) Does your patient have Stage III disease? 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 drug requested has NOT been previously used
- ☐ being given as reintroduction therapy
- ☐ none of the above

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

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

(if CRC or non-pNET or small bowel adenocarcinoma) Will the drug requested be taken in combination with Opdivo (nivolumab)? 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 CRC) Has your patient's disease progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan (Camptosar)? 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 MPM) Has your patient previously used any type of systemic therapy for this diagnosis? Yes ☐ No ☐

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

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

(if not high 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 HCC) Has your patient been previously treated with sorafenib (Nexavar)? Yes ☐ No ☐

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

(if SCLC) Has your patient previously received any type of therapy (before the drug requested) for the treatment of small cell lung cancer? Yes ☐ No ☐

(if 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 ☐

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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