ATRIO HEALTH PLANS

Monoclonal Antibody: T-lymphocite Agents
Yervoy (ipilimumab) J9228
Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

For questions or assistance, please contact Customer Service at 1-877-672-8620, daily, 8am – 8pm (PST) (TTY users should call 1-800-735-2900).

Prior Authorization Group – Anti-Neoplastic – Monoclonal Antibodies – T-Lymphocite Agents PA

Drug Name(s):

YERVOY
IPILIMUMAB

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Prescribed by, or in consultation with an oncologist or other cancer specialist related to the diagnosis.
3. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
4. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Initial approval will be for 6 months
Continuation approval will be for 12 months

FDA Indications:

Yervoy

- Liver carcinoma, In patients previously treated with sorafenib, in combination with nivolumab
- Malignant melanoma, Adjuvant, cutaneous with involvement of regional lymph nodes (greater than 1 mm) following complete resection, including lymphadenectomy
- Malignant melanoma, Unresectable or metastatic disease, in combination with nivolumab
- Malignant melanoma, Unresectable or metastatic disease, monotherapy
- Malignant mesothelioma of pleura, Unresectable disease, first-line treatment
- Metastatic colorectal cancer, In combination with nivolumab, after progression following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan - Microsatellite instability-high, Or mismatch repair deficient
- Non-small cell lung cancer, Metastatic, PD-L1 expression with no EGFR or ALK tumor aberrations, first-line treatment, in combination with nivolumab
- Non-small cell lung cancer, Metastatic or recurrent, no EGFR or ALK tumor aberrations, first-line treatment, in combination with nivolumab and 2 cycles of platinum-doublet chemotherapy
- Renal cell carcinoma, Advanced, intermediate or poor risk, first-line, in combination with nivolumab

Off-Label Uses:

- Malignant melanoma, Cutaneous with involvement of regional lymph nodes following complete resection; Adjuvant
- Malignant melanoma, Unresectable or metastatic
- Renal cell carcinoma, Advanced, previously untreated, intermediate or poor risk, in combination with nivolumab
- Secondary malignant neoplasm of brain

Age Restrictions:

12 years or older

Other Clinical Considerations:

N/A

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/13CBB2/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/DB86DE/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=Ipilimumab&UserSearchTerm=Ipilimumab&SearchFilter=filterNone&navitem=searchGlobal#