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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Yervoy® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information (required)					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Colorectal cancer					
<input type="checkbox"/> Melanoma					
<input type="checkbox"/> Renal cell carcinoma					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Prescriber's Specialty:</b>					
Is Yervoy prescribed by or in consultation with an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>For colorectal cancer, answer the following:</b>					
Does the patient have microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer (CRC)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if the patient has experienced disease progression following treatment with the following:					
<input type="checkbox"/> Fluoropyrimidine					
<input type="checkbox"/> Oxaliplatin					
<input type="checkbox"/> Irinotecan					
Will the patient use Yervoy in combination with Opdivo (nivolumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>For melanoma, answer the following:</b>					
Does the patient have unresectable or metastatic disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have cutaneous melanoma? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have pathologic involvement of regional lymph nodes of more than 1 millimeter? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient undergone resection, including total lymphadenectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>For renal cell carcinoma, answer the following:</b>					
Does the patient have advanced, relapsed, or stage IV disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have surgically unresectable disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have intermediate- or poor-prognosis risk? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have previously untreated disease? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will Yervoy be used in combination with Opdivo (nivolumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Reauthorization:</b>					
Does the patient show evidence of progressive disease while on Yervoy therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Yervoy\_Comm\_2018Dec-W



**Yervoy<sup>®</sup> Prior Authorization Request Form (Page 2 of 2)**  
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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-800-711-4555.  
This form may be used for non-urgent requests and faxed to 1-800-527-0531.