OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Opdivo® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Classical Hodgkin lymphoma (cHL)
- ❑ Colorectal cancer
- ❑ Head and neck squamous cell carcinoma (HNSCC)
- ❑ Hepatocellular carcinoma (HCC)
- ❑ Melanoma
- ❑ Non-small cell lung cancer (NSCLC)
- ❑ Renal cell carcinoma (RCC)
- ❑ Urothelial carcinoma
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is Opdivo prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**
Is this request for continuation of prior Opdivo therapy? ❑ **Yes** ❑ **No**
Has the patient used Opdivo within the past 120 days? ❑ **Yes** ❑ **No**

For classical Hodgkin lymphoma, also answer the following:

Select if the patient has had relapse or progression after the following therapies or procedures:

- ❑ Autologous hematopoietic stem cell transplantation (HSCT)
- ❑ Adcetris (brentuximab vedotin)
- ❑ Three or more lines of systemic therapy that includes autologous HSCT

For colorectal cancer, also answer the following:

Does the patient have a diagnosis of microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) metastatic colorectal cancer (CRC)? ❑ **Yes** ❑ **No**
Has the patient experienced disease progression following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan? ❑ **Yes** ❑ **No**

For head and neck squamous cell carcinoma, also answer the following:

Does the patient have recurrent or metastatic head and neck squamous cell carcinoma? ❑ **Yes** ❑ **No**
Has the patient experienced disease progression on or after platinum-containing therapy (e.g., cisplatin, carboplatin)? ❑ **Yes** ❑ **No**

For hepatocellular carcinoma (HCC), also answer the following:

Has the patient had previous treatment with Nexavar (sorafenib)? ❑ **Yes** ❑ **No**

Opdivo® Prior Authorization Request Form (Page 2 of 2)

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For melanoma, also answer the following:

Does the patient have unresectable or metastatic disease? ❑ **Yes** ❑ **No**

Will Opdivo be used in the adjuvant setting following complete resection of Stage IIIB/C (lymph node involvement) or Stage IV (metastatic) disease? ❑ **Yes** ❑ **No**

For non-small cell lung cancer (NSCLC), also answer the following:

Does the patient have metastatic disease? ❑ **Yes** ❑ **No**

Has the patient experienced disease progression on or after platinum-based chemotherapy (e.g., cisplatin, carboplatin)? ❑ **Yes** ❑ **No**

Does the patient have epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations? ❑ **Yes** ❑ **No**

Select if the patient has experienced disease progression on the following therapies:

- ❑ One anti-EGFR therapy (e.g., Gilotrif [afatinib], Iressa [gefitinib], Tarceva [erlotinib])
- ❑ One ALK inhibitor (e.g., Alecensa [alectinib], Xalkori [crizotinib], Zykadia [ceritinib])

For renal cell carcinoma (RCC), also answer the following:

Does the patient have advanced, relapsed, or Stage IV disease that is surgically unresectable? ❑ **Yes** ❑ **No**

Has the patient received at least one anti-angiogenic therapy [e.g., Sutent [sunitinib], Nexavar [sorafenib]])? ❑ **Yes** ❑ **No**

Does the patient have intermediate- or poor-prognosis risk? ❑ **Yes** ❑ **No**

Does the patient have previously untreated disease? ❑ **Yes** ❑ **No**

Will Opdivo be used in combination with Yervoy (ipilimumab)? ❑ **Yes** ❑ **No**

For urothelial carcinoma, also answer the following:

Does the patient have locally advanced or metastatic disease? ❑ **Yes** ❑ **No**

Has the patient had disease progression during or following platinum-containing chemotherapy? ❑ **Yes** ❑ **No**

Has the patient had disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.