

CRITERIA FOR PRIOR AUTHORIZATION

Opdivo® (nivolumab)

PROVIDER GROUP Pharmacy
MANUAL GUIDELINES The following drug requires prior authorization:
Nivolumab (Opdivo®)

CRITERIA FOR APPROVAL (must meet all of the following):

- Patient must have one of the following diagnoses:
 - Unresectable or metastatic melanoma
 - Medication must be used as a single agent or in combination with ipilimumab
 - Metastatic non-small cell lung cancer with disease progression on or after platinum-based chemotherapy
 - If EGFR or ALK mutation present, patient must have failure with a mutation specific medication prior to using Opdivo
 - Advanced renal cell carcinoma
 - Patient must have received prior anti-angiogenic therapy
 - Classical Hodgkin lymphoma that has relapsed or progressed after autologous hematopoietic stem cell transplantation (HSCT) and post-transplantation brentuximab vedotin
- Must be prescribed by or in consultation with an oncologist
- Patient must be 18 years of age or older

LENGTH OF APPROVAL: 12 months

DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

DATE

DATE