P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth

PREAUTHORIZATION FORM

Yervoy™
(ipilimumab)

Therapeutic use: Human cytotoxic T-lymphocyte antigen 4 (CTLA-4)-blocking antibody indicated for the treatment of unresectable or metastatic melanoma
Quantity Limit: 3mg/kg every three weeks for four doses
Authorization Period: 6 months

Patient's name _____

Patient's ID# ☐☐☐ ☐☐ ☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐ ☐☐ ☐☐☐ ☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐) ☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the prescriber an oncologist or hematologist?	❑ Yes	❑ No
2.	Has the patient been diagnosed with unresectable or metastatic melanoma?	❑ Yes	❑ No
3.	Is Yervoy being used as monotherapy?	❑ Yes	❑ No
• Yervoy should not be administered to patients with an active autoimmune disease or those receiving systemic immunosuppression for organ transplantation.			

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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Last Updated: 09/212011