State of Oklahoma
Oklahoma Health Care Authority

Keytruda® (Pembrolizumab) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

❑ **Physician billing (HCPCS code:** _____**)** ***Start Date (or date of next dose):*** _____

Dose: _____ ***Regimen:*** _____

Billing Provider Information

SoonerCare Provider ID: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate the requested information:
   - A. Has the member previously failed other PD-1 inhibitors [e.g., Opdivo® (nivolumab)]? Yes ☐ No ☐
   - B. Will pembrolizumab be used as a single-agent? Yes ☐ No ☐
2. Please indicate the diagnosis and information:
   - ☐ **Unresectable or Metastatic Melanoma**
     - A. Will pembrolizumab be used as first-line therapy? Yes ☐ No ☐
     - B. Will pembrolizumab be used as second-line or subsequent therapy for disease progression if not previously used? Yes ☐ No ☐
     - C. If using for 2nd line or subsequent therapy, please indicate member's ECOG performance status: ___
   - ☐ **Hodgkin Lymphoma**
     - A. Is diagnosis refractory or relapsed classical Hodgkin lymphoma? Yes ☐ No ☐
     - B. Is diagnosis lymphocyte-predominant Hodgkin lymphoma? Yes ☐ No ☐
   - ☐ **Metastatic Non-Small Cell Lung Cancer (NSCLC)**
     - A. Does tumor express PD-L1? Yes ☐ No ☐
       - i. If yes (tumor is PD-L1 positive), please provide the tumor proportion score (%): ____
     - B. Will pembrolizumab be used as first-line therapy for new diagnosis (member has not received chemotherapy to treat disease)? Yes ☐ No ☐
     - C. Will pembrolizumab be used for previously untreated metastatic non-squamous NSCLC in combination with pemetrexed and carboplatin? Yes ☐ No ☐
     - D. Will pembrolizumab be used following disease progression on or after platinum-containing chemotherapy (cisplatin or carboplatin)? Yes ☐ No ☐
     - E. Does tumor express sensitizing Epidermal Growth Factor Receptor (EGFR) mutations or Anaplastic Lymphoma Kinase (ALK) translocations? Yes ☐ No ☐
     - F. In members with EGFR-mutation-positive disease or ALK genomic tumor aberrations, has member had disease progression on FDA-approved therapy for these aberrations prior to receiving pembrolizumab? Yes ☐ No ☐
       - i. If yes, please provide information on previous therapy: _____
     - G. Please indicate member's ECOG performance status: ___

Please complete and return all pages. *Failure to complete all pages will result in processing delays.*
Please do not send in chart notes. Specific information will be requested if necessary.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Keytruda® (Pembrolizumab) Prior Authorization Form

Member Name: _____ ***Date of Birth:***_____ ***Member ID#:***_____

Criteria

Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

2. Please indicate the diagnosis and information, continued:

☐ **Recurrent or Metastatic Head and Neck Cancer**
- A. Is the histology squamous cell? Yes☐ No☐
- B. Has member previously received platinum-containing regimen (cisplatin or carboplatin)? Yes☐ No☐
- C. Please indicate member's ECOG performance status: ___

☐ **Urothelial Carcinoma**
- A. Does member have locally advanced or metastatic urothelial carcinoma? Yes☐ No☐
- B. Will pembrolizumab be used following disease progression on or after platinum-containing chemotherapy? Yes☐ No☐
- C. Will pembrolizumab be used within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy? Yes☐ No☐
- D. Will pembrolizumab be used as frontline therapy? Yes☐ No☐
- E. Is member eligible for cisplatin-containing chemotherapy? Yes☐ No☐
  - i. If member is not eligible for cisplatin-containing chemotherapy, please indicate reason for cisplatin ineligibility:
    - ☐ Baseline creatinine clearance of <60mL/min
    - ☐ ECOG performance status of 2
    - ☐ Class III heart failure
    - ☐ Grade 2 or greater peripheral neuropathy
    - ☐ Grade 2 or greater hearing loss
    - ☐ Other: _____

☐ **Microsatellite Instability-high (MSI-H) or Mismatch Repair Deficient (dMMR) Solid Tumors (Tissue/site-agnostic)**
- A. Does member have MSI-H or dMMR solid tumors that have progressed following prior treatment with no satisfactory alternative treatment options? Yes☐ No☐
- B. Does member have MSI-H or dMMR colorectal cancer that has progressed following treatment with a fluoropyrimidine, oxaliplatin and irinotecan? Yes☐ No☐

☐ **Gastric or Gastroesophageal Junction Tumors**
- A. Is diagnosis recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma? Yes☐ No☐
- B. Does tumor express PD-L1? Yes☐ No☐
- C. Does member have disease progression on or after 2 or more prior systemic therapies (including fluoropyrimidine- and platinum-containing chemotherapy and, if appropriate, HER2/neu-targeted therapy)? Yes☐ No☐

☐ If answer is none of the above, please indicate diagnosis:_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on pembrolizumab? Yes____ No____
3. Has the member experienced any adverse drug reactions related to pembrolizumab therapy? Yes____ No____

*If yes, please specify adverse reactions:*_____

Please complete and return all pages. ***Failure to complete all pages will result in processing delays.***

Prescriber Signature: _____ **Date:**_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*