SoonerCare
Oklahoma Health Care Authority

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:_____)**

Dose: _____ ***Regimen:*** _____ ***Start Date:*** _____

Billing Provider Information

Provider NPI: _____ ***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 <u>all</u> 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 (0-5):_____

☐ **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 ☐
- B. Will pembrolizumab be used as first-line therapy for new diagnosis? 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 EGFR mutations or ALK translocations? Yes ☐ No ☐
- F. If tumor is EGFR-mutation-positive or has 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 (0-5):_____

☐ **Recurrent or Metastatic Head and Neck Cancer**
- A. Does member have head and neck squamous cell carcinoma? Yes ☐ No ☐
- B. Has member previously received platinum-containing chemotherapy? Yes ☐ No ☐
- C. Please indicate member's ECOG performance status (0-5):_____

☐ **Recurrent or Metastatic Cervical Cancer**
- A. Has member experienced disease progression on or after chemotherapy? Yes ☐ No ☐
- B. Does tumor express PD-L1? Yes ☐ No ☐
  - i. If yes, please provide the Combined Positive Score (CPS)_____

Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.

<u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u>	<u>CONFIDENTIALITY NOTICE</u>
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.*

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2. Please indicate the diagnosis and information, continued:
   - ❑ **Primary Mediastinal Large B-cell Lymphoma (PMBCL)**
     - A. Does member have refractory disease? Yes☐ No☐
     - B. Has member relapsed after 2 or more prior lines of therapy? Yes☐ No☐
     - C. Does member require urgent cytoreduction? Yes☐ No☐
   - ❑ **If answer is none of the above, please indicate diagnosis:**_____

Additional Information:_____
_____

For Continued Authorization:
1. Does member have any evidence of progressive disease while on pembrolizumab? Yes☐ No☐
2. Has the member experienced any adverse drug reactions related to pembrolizumab therapy? Yes☐ No☐
   *If yes, please specify adverse reactions:*_____
_____

Please complete and return <u>all</u> 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. Failure to complete this form in full will result in processing delays.

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