

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

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 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 (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. Please indicate the tumor proportion score for PD-L1 expression: _____ (%)
- B. Will pembrolizumab be used as first-line therapy for new diagnosis? Yes ___ No ___
- C. Will pembrolizumab be used for previously untreated metastatic squamous NSCLC in combination with carboplatin and either paclitaxel or nab-paclitaxel? Yes ___ No ___
- D. Will pembrolizumab be used for previously untreated metastatic non-squamous NSCLC in combination with pemetrexed and carboplatin? Yes ___ No ___
- E. Will pembrolizumab be used following disease progression on or after platinum-containing chemotherapy (cisplatin or carboplatin)? Yes ___ No ___
- F. Does tumor express sensitizing EGFR mutations or ALK translocations? Yes ___ No ___
- G. 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: _____
- H. 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): _____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

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

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**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 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) _____

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 ___

Hepatocellular Carcinoma (HCC)

- A. Does member have relapsed or progressive disease? Yes ___ No ___
- B. Has member been previously treated with sorafenib? Yes ___ No ___

Merkel Cell Carcinoma (MCC)

- A. Does member have recurrent locally advanced or metastatic MCC? Yes ___ No ___
- B. Does member have a history of prior systemic chemotherapy? Yes ___ No ___

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

Additional Information: _____

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: _____

DRAFT

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. Failure to complete this form in full will result in processing delays.

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