PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Keytruda (pembrolizumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:		**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:		Fax:	Phone:
Date of Birth:		Office Contact:	
Group Number:		NPI:	State Lic ID:
Address:	Address:		
City, State ZIP:		City, State ZIP:	
Primary Phone:		Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Please provide ICD code(s) for diagnosis.

Q2. For which diagnosis is Keytruda (pembrolizumab) being prescribed?

- ☐ Unresectable or metastatic melanoma
- ☐ Metastatic non-small cell lung cancer (NSCLC)
- ☐ Recurrent or metastatic squamous cell carcinoma of the head and neck
- ☐ Other (please specify)

Q3. If you selected "other" in question 2, please provide documentation that use is consistent with a category 2A or higher recommendation per NCCN compendia or guidelines.

Q4. Please indicate location of administration.

- ☐ Home
- ☐ Long Term Care (LTC) facility
- ☐ Physician office (drug from office stock - buy and bill)
- ☐ Physician office (drug from pharmacy with a prescription)

Q5. Is the prescriber an Oncologist or Hematologist?

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☐ Yes ☐ No

Q6. If using Keytrude for NSCLC, are the tumors PD-L1 positive as determined by an FDA-approved test?

☐ Yes ☐ No

Q7. If using for NSCLC and tumor has EGFR or ALK genomic tumor aberrations, has patient had disease progression on approved EGFR or ALK directed therapy?

☐ Yes ☐ No

Q8. If using Keytruda for NSCLC or squamous cell carcinoma of the head and neck, did the patient have disease progression on or after platinum-containing chemotherapy?

☐ Yes ☐ No

Q9. Will the patient be using systemic corticosteroids and / or immunosuppressants while taking Keytruda?

☐ Yes ☐ No

Q10. Does the patient have a history of severe immune-mediated adverse reaction from treatment with ipilimumab, requiring use of corticosteroids for 12 weeks for more?

☐ Yes ☐ No

Q11. Additional Comments

Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been

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decided.