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 Head and Neck Squamous Cell Cancer (HNSCC)
- ☐ Refractory Classical Hodgkin Lymphoma (cHL)
- ☐ Locally Advanced or Metastatic Urothelial Carcinoma
- ☐ Other (please specify)

Q3. If you selected "other" in question 2, please provide documentation that use is consistent with a category 1 recommendation per NCCN compendia or guidelines.

Q4. Is the prescriber an Oncologist or Hematologist?

☐ Yes ☐ No

Q5. If using for NSCLC, are the tumors PD-L1 positive as determined by an FDA-approved test?

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:**

☐ Yes, Tumor Proportion Score > 1%
☐ Yes, Tumor Proportion Score > 50%
☐ No or Unknown

Q6. If using for NSCLC, does the patient have EGFR or ALK genomic tumor aberrations?

☐ 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 for metastatic nonsquamous NSCLC, will Keytruda be using in combination with Alimta and carboplatin?

☐ Yes ☐ No

Q9. If using Keytruda for NSCLC or HNSCC, did the patient have disease progression on or after platinum-containing chemotherapy?

☐ Yes ☐ No

Q10. If using for cHL, has the patient relapsed after 3 or more prior lines of therapy?

☐ Yes ☐ No

Q11. If for urothelial carcinoma, is the patient eligible for cisplatin-containing chemotherapy?

☐ Yes ☐ No

Q12. If for urothelial carcinoma, did the patient have disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy?

☐ Yes ☐ No

Q13. Will the patient be using systemic corticosteroids and / or immunosuppressants while taking Keytruda?

☐ Yes ☐ No

Q14. 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

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:**

Q15. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility
- ☐ Other (please specify)

Q16. Provide name and NPI of the billing entity

Q17. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q18. 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 a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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.**

	Prescriber Name:
Patient Name:	**Supervising Physician:**