OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-348-3720**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process.**

Drug Requested: KEYTRUDA® (pembrolizumab) **(J9271) (Medical)**

DRUG INFORMATION: Please complete below or authorization will be delayed.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code**: _____

- **Injection dose based on diagnosis**.

CLINICAL CRITERIA: Check **all** boxes that apply to ensure authorization will **NOT** be delayed.

- **Patients who have been diagnosed with one of the following:**
  - ❑ **Melanoma** – for the treatment of unresectable or metastatic

    OR

  - ❑ **Metastatic non-small cell lung cancer (NSCLC)**
    - ❑ as a single agent for the first-line treatment of patients with NSCLC whose tumors have high PD-L1 tumor expression [Tumor Proportion Score (TPS) ≥ 50%] determined by a FDA approved test, with no EGFR or ALK genomic tumor aberrations
    - ❑ as a single-agent for the treatment of patients with NSCLC whose tumors express PD-L1 tumor expression [Tumor Proportion Score (TPS) ≥1%] determined by a FDA approved test, with disease progression on or after platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving Keytruda
    - ❑ in combination with pemetrexed and carboplatin, as first-line treatment of patients with metastic nonsquamous NSCLC.

      OR

  - ❑ **Head and Neck Squamous Cell Cancer (HNSCC)** – for the treatment of patients with recurrent or metastatic HNSCC with disease progression on or after platinum-containing chemotherapy

    OR

  - ❑ **Classical Hodgkin Lymphoma (cHL)** – for the treatment of adult and pediatric patients with refractory cHL or who have relapsed after 3 or more prior lines of therapy

    OR

(continued on next page)

- ❑ **Urothelial Carcinoma**
  - ❑ for the treatment of patients with locally advanced or metastatic urothelial carcinoma who are not eligible for cisplatin-containing chemotherapy
  - ❑ for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy

OR

- ❑ **Microsatellite Instability-High Cancer**
  - ❑ for the treatment of adult and pediatric patients with unresectable or metastatic, microsatellite instability-high (MSI-H) or mismatch repair deficient
  - ❑ for the treatment of patients with locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy

Medication being provided by (check applicable box below):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy - PropriumRx**

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~8/1/2017; 5/25/2018; 8/23/2018;~~ **10/8/2018**