OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION 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 1-844-202-5034. 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: C***omplete all information below or authorization process will be delayed.***

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code**: _____

- ***Injection dose based on diagnosis***.

CLINICAL CRITERIA: Check all boxes that apply to ensure authorization process 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
  - ❑ **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

(continued on next page)

- **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 – Briova SpecialtyRx**

*****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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 1/13/2017
REVISED/UPDATED: ~~3/28/2017~~; ~~6/8/2017~~; ~~7/13/2017~~; ~~7/27/2017~~; **7/10/2018**;