

OPTIMA HEALTH PLAN

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 1-844-723-2094. 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. Incomplete information will delay authorization process.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

- Injection dose based on diagnosis.

CLINICAL CRITERIA: Check all boxes that apply. If applicable boxes are not checked, authorization process will 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) \geq 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) \geq 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 metastatic 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:

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 #: _____

*Approved by Pharmacy and Therapeutics Committee: 1/13/2017
REVISED/UPDATED: 3/28/2017; 6/8/2017; 7/13/2017; 7/27/2017. 5/24/2018.