Keytruda

HMSA - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Criteria Questions:

1. Indicate where the drug is being administered?
   ❑ Ambulatory surgical ❑ Home ❑ Inpatient hospital ❑ Office ❑ Outpatient treatment center ❑ Pharmacy

2. What is the specialty of the practitioner who recommended Keytruda?
   ❑ Oncologist
   ❑ Hematologist
   ❑ Other_____

3. What is the diagnosis? ***Action Required*: Please attach current oncology notes, clinical notes that include the history of previous treatments, and any pertinent pathology reports and/or imaging studies.**
   ❑ Melanoma
   ❑ Non-small cell lung cancer
   ❑ Head and neck cancer
   ❑ Classical Hodgkin lymphoma
   ❑ Urothelial carcinoma
   ❑ Colorectal cancer, microsatellite instability-high (MSI-H) or mismatch repair deficient
   ❑ Solid tumor (other than colorectal cancer), microsatellite instability-high (MSI-H) or mismatch repair deficient
   ❑ Merkel cell carcinoma
   ❑ Gastric carcinoma
   ❑ Other _____

4. What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

5. Was Keytruda therapy previously authorized by HMSA/CVS for this member?
   If Yes, skip to #44 ❑ Yes ❑ No ❑ Unknown

6. Will Keytruda be used as a single agent? ❑ Yes ❑ No

Complete the following section based on the member's diagnosis

Section A: Melanoma

7. Is the melanoma unresectable or metastatic? ❑ Yes ❑ No

8. What is the intent of treatment?
   ❑ Initial/first-line therapy, *no further questions*
   ❑ Re-induction therapy, *no further questions*
   ❑ Second-line or subsequent therapy
   ❑ Other _____

9. Did the member experience disease progression following previous therapy or maximum clinical benefit from BRAF targeted therapy? ❑ Yes ❑ No

   Please document previous therapy: _____

Section B: Non-small Cell Lung Cancer

10. Is the NSCLC metastatic? ❑ Yes ❑ No

11. Was testing performed for tumor PD-L1 expression? ***Action Required: If yes, please attach a copy of the laboratory report.*** ❑ Yes ❑ No

12. What is the intent of treatment?
   ❑ First line therapy, *skip to #16*
   ❑ Subsequent therapy following targeted therapy only, *skip to #16*
   ❑ Subsequent therapy following chemotherapy or other systemic therapy
   ❑ Other _____

13. What is the tumor PD-L1 protein expression status?
   ❑ Positive (Tumor Proportion Score ≥1%)
   ❑ Negative
   ❑ Unknown

14. Will Keytruda be used for disease progression on or after the first line cytotoxic therapy? ***Action Required: Please attach documentation (eg, member's chart or medical record) that supports the first line cytotoxic therapy received (eg, regimens and dates).*** *If Yes, no further questions* ❑ Yes ❑ No

15. Will Keytruda be used for further disease progression on other systemic therapy? ***Action Required: Please attach documentation (eg, member's chart or medical record) that supports the other systemic therapy received (eg, regimens and dates).*** ❑ Yes ❑ No *No further questions*

16. Does the patient have the nonsquamous type of non-small cell lung cancer? ❑ Yes ❑ No *If No, skip to #18*

17. Will Keytruda be used in combination with pemetrexed and carboplatin?
   If Yes, no further questions ❑ Yes ❑ No

18. Does the tumor have high PD-L1 protein expression (Tumor Proportion Score ≥50%)? ❑ Yes ❑ No ❑ Unknown

19. Does the tumor have EGFR, ALK or ROS1 genomic aberrations?
   ❑ Yes
   ❑ No, *no further questions*
   ❑ Unknown, *no further questions*

20. Has the cancer progressed on an FDA-approved therapy for one of these mutations prior to receiving Keytruda?
   ❑ Yes ❑ No

Section C: Head and Neck Cancer

21. Does the member have recurrent or metastatic head and neck cancer? ❑ Yes ❑ No

22. Does the member have any of the following conditions: diagnosed with T4b disease, unresectable nodal disease or is unfit for surgery? ❑ Yes ❑ No

23. Is the cancer histology squamous cell carcinoma? ❑ Yes ❑ No

24. Will Keytruda be used for cancer that progressed on or after a platinum-containing chemotherapy regimen? ***Action Required: Please attach documentation (eg, member's chart or medical record) of previous platinum-containing chemotherapy (eg, regimen and dates).*** ❑ Yes ❑ No

Section D: Classical Hodgkin Lymphoma

25. Does the patient have relapsed or refractory classic Hodgkin lymphoma? ❑ Yes ❑ No

Section E: Merkel Cell Carcinoma

26. Does the patient have distant metastatic disease or disseminated recurrence? ❑ Yes ❑ No

Section F: Urothelial Carcinoma

27. Is the urothelial carcinoma locally advanced or metastatic? ❑ Yes ❑ No

28. Has the patient experienced disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy? *If Yes, no further questions* ❑ Yes ❑ No

29. Has the patient experienced disease progression during or following platinum-containing chemotherapy? *If Yes, no further questions* ❑ Yes ❑ No

30. Is the patient NOT eligible to receive cisplatin-containing chemotherapy (for example, patient has impaired renal function or poor performance status)? ❑ Yes ❑ No

Section G: Colorectal Cancer With MSI-H/dMMR

31. Is the colorectal cancer unresectable or metastatic? ❑ Yes ❑ No

32. Does the tumor have high microsatellite instability or defective mismatch repair (dMMR/MSI-H)? ❑ Yes ❑ No

Section H: Solid Tumors With MSI-H/dMMR (other than colorectal cancer)

33. What is the solid tumor type?
    - ❑ Breast cancer
    - ❑ Prostate cancer
    - ❑ Endometrial cancer
    - ❑ Gastric cancer
    - ❑ Biliary cancer
    - ❑ Pancreatic cancer
    - ❑ Other_____

34. Is the cancer unresectable or metastatic? ❑ Yes ❑ No

35. Does the solid tumor have high microsatellite instability or defective mismatch repair (dMMR/MSI-H)? ❑ Yes ❑ No

36. Is Keytruda prescribed for a pediatric patient with a central nervous system cancer? ❑ Yes ❑ No

37. Has the patient experienced disease progression following previous treatment? ❑ Yes ❑ No

38. Are there any other satisfactory alternative treatment options available for this patient? ❑ Yes ❑ No

Section I: Gastric Carcinoma

39. Does the patient have recurrent locally advanced, metastatic gastric or gastroesophageal junction adenocarcinoma? ❑ Yes ❑ No

40. What is the patient's PD-L1 protein expression status? ❑ Positive ❑ Negative

41. Has the patient experienced disease progression on or after two or more lines of therapy including fluoropyrimidine and platinum containing chemotherapy? ❑ Yes ❑ No

42. What is the HER2 status of the disease? ❑ Positive ❑ Negative

43. Did the patient receive HER2 targeted therapy? ❑ Yes ❑ No

Section J: Reauthorization

44. Is there evidence of disease progression? ***Action Required: Please attach documentation including clinical notes and objective findings such as imaging studies that demonstrate lack of disease progression on therapy.***
❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512