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 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization will be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

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

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code**: _____

- **Injection dose based on diagnosis**.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- **Members 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 Members 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 Members 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. Members 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 Members with metastic nonsquamous NSCLC.

      OR

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

    OR

(Continued on next page)

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

OR

- ❑ **Urothelial Carcinoma**
  - ❑ for the treatment of Members with locally advanced or metastatic urothelial carcinoma who are not eligible for cisplatin-containing chemotherapy
  - ❑ for the treatment of Members 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 Members with unresectable or metastatic, microsatellite instability-high (MSI-H) or mismatch repair deficient
  - ❑ for the treatment of Members 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 box below that applies):

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

  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Optima Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Optima's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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.****

Member 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~~; **(Reformatted)** ~~3/17/2019~~; ~~7/7/2019~~; **9/23/2019**;