Prescriber Criteria Form Keytruda 2024 PA Fax 1185-A v7 010124.docx Keytruda (pembrolizumab) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Keytruda (pembrolizumab).

Drug Name: Keytruda (pembrolizumab)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of either of the following: A) unresectable, inoperable, advanced, or metastatic colon cancer, including appendiceal adenocarcinoma, B) unresectable, inoperable, advanced, recurrent, or metastatic rectal cancer? [If no, then skip to question 3.]	Yes	No
2	Does the patient have microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease? [No further questions.]	Yes	No
3	Does the patient have a diagnosis of gastric, esophagogastric junction, or esophageal cancer? [If yes, then no further questions.]	Yes	No
4	Does the patient have a diagnosis of persistent, unresectable, recurrent, or metastatic cervical cancer? [If yes, then no further questions.]	Yes	No
5	Does the patient have a diagnosis of solid tumor (e.g., osteosarcoma, chondrosarcoma, chordoma, Ewing sarcoma, penile cancer, breast cancer) that meets ALL of the following criteria: A) unresectable or metastatic, B) microsatellite instability-high (MSI-H), mismatch repair deficient (dMMR), or tumor mutational burden-high (greater than or equal to 10 mutations per megabase [mut/Mb]), C) disease progressed following prior treatment and	Yes	No

	patient has no satisfactory alternative treatment options? [If yes, then no further questions.]		
6	Does the patient have a diagnosis of unresectable, recurrent, stage III, or metastatic cutaneous melanoma? [If yes, then no further questions.]	Yes	No
7	Will the requested drug be used for adjuvant treatment of melanoma? [If yes, then no further questions.]	Yes	No
8	Does the patient have a diagnosis of non-small cell lung cancer? [If yes, then no further questions.]	Yes	No
9	Does the patient have a diagnosis of head and neck cancer? [If no, then skip to question 13.]	Yes	No
10	Is the head and neck cancer very advanced disease? [If yes, then no further questions.]	Yes	No
11	Does the patient have unresectable, recurrent, or metastatic nasopharyngeal cancer? [If yes, then no further questions.]	Yes	No
12	Does the patient have salivary gland tumors of the head and neck that meet any of the following: A) tumor mutational burden high (TMB-H), B) mismatch repair deficient (dMMR), C) microsatellite instability-high (MSI-H)? [No further questions.]	Yes	No
13	Does the patient have a diagnosis of Bacillus Calmette-Guerin (BCG)-unresponsive, high risk, non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS)? [If no, then skip to question 15.]	Yes	No
14	Is the patient ineligible for or has the patient elected not to undergo cystectomy? [No further questions.]	Yes	No
15	Does the patient have a diagnosis of urothelial carcinoma (other than non-muscle invasive bladder cancer [NMIBC] with carcinoma in situ)? [If yes, then no further questions.]	Yes	No
16	Does the patient have a diagnosis of relapsed or refractory primary mediastinal large B-cell lymphoma (PMBCL)? [If yes, then no further questions.]	Yes	No
17	Does the patient have a diagnosis of hepatocellular carcinoma? [If yes, then no further questions.]	Yes	No
18	Does the patient have a diagnosis of renal cell carcinoma? [If yes, then no further questions.]	Yes	No
19	Does the patient have a diagnosis of cutaneous squamous cell carcinoma (cSCC) that meets BOTH of the following: A) the disease is recurrent, metastatic, or locally advanced,	Yes	No

	B) the disease is not curable by surgery or radiation? [If yes, then no further questions.]		
20	Does the patient have a diagnosis of invasive or inflammatory breast cancer? [If yes, then no further questions.]	Yes	No
21	Does the patient have a diagnosis of Merkel cell carcinoma? [If yes, then no further questions.]	Yes	No
22	Does the patient have a diagnosis of endometrial carcinoma? [If yes, then no further questions.]	Yes	No
23	Does the patient have any of the following diagnoses: A) relapsed, refractory, or progressive classical Hodgkin lymphoma, B) epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer, C) uveal melanoma , D) testicular cancer, E) anal carcinoma, F) treatment of central nervous system (CNS) brain metastases, in a patient with melanoma or non-small cell lung cancer (NSCLC), G) pancreatic adenocarcinoma, H) biliary tract cancer (extrahepatic cholangiocarcinoma, intrahepatic cholangiocarcinoma, gallbladder cancer), I) squamous cell skin cancer, J) uterine sarcoma, K) small cell lung cancer? [If yes, then no further questions.]	Yes	No
24	Does the patient have any of the following diagnoses: A) vulvar cancer, B) thymic carcinoma, C) Mycosis Fungoides/Sezary syndrome, D) extranodal natural killer (NK)/T-cell lymphoma, E) gestational trophoblastic neoplasia, F) extrapulmonary poorly differentiated neuroendocrine carcinoma/large or small cell carcinoma/mixed neuroendocrine-non-neuroendocrine neoplasm, G) soft tissue sarcomas (extremity/body wall, head/neck, retroperitoneal/intra-abdominal, rhabdomyosarcoma, alveolar soft part sarcoma [ASPS], cutaneous angiosarcoma), H) occult primary cancer, I) adrenocortical carcinoma, J) thyroid carcinoma (anaplastic, follicular, oncocytic, papillary, medullary), K) small bowel adenocarcinoma, L) ampullary adenocarcinoma, M) well-differentiated grade 3 neuroendocrine tumors, N) prostate cancer, O) cutaneous anaplastic large cell lymphoma (ALCL), P) pediatric diffuse high-grade gliomas, Q) Kaposi sarcoma?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____