OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Keytruda® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Classical Hodgkin lymphoma (cHL)
- ❑ Gastric cancer
- ❑ Head and neck squamous cell carcinoma (HNSCC)
- ❑ Melanoma
- ❑ Microsatellite instability-high cancer
- ❑ Non-small cell lung cancer (NSCLC)
- ❑ Urothelial carcinoma
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is Keytruda prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**
Is this request for continuation of prior Keytruda therapy? ❑ **Yes** ❑ **No**
Has the patient used Keytruda within the past 120 days? ❑ **Yes** ❑ **No**

For classical Hodgkin lymphoma, also answer the following:

Does the patient have refractory disease? ❑ **Yes** ❑ **No**
Has the patient's disease relapsed after 3 or more prior lines of therapy? ❑ **Yes** ❑ **No**

For gastric cancer, also answer the following:

Does the patient have gastric or gastroesophageal junction adenocarcinoma? ❑ **Yes** ❑ **No**
Select if the patient has the following disease characteristics:
❑ Locally advanced ❑ Metastatic ❑ Recurrent
Do tumors express PD-L1 (Combined Positive Score [CPS] greater than or equal to 1) as determined by an FDA-approved test? ❑ **Yes** ❑ **No**
Has the patient experienced disease progression on or after two or more lines of therapy including fluoropyrimidine- and platinum-containing chemotherapy? ❑ **Yes** ❑ **No**
If the patient is HER2/neu positive, has the patient experienced disease progression on or after HER2/neu-targeted therapy? ❑ **Yes** ❑ **No**

For head and neck squamous cell carcinoma, also answer the following:

Does the patient have recurrent or metastatic head and neck squamous cell carcinoma? ❑ **Yes** ❑ **No**
Has the patient experienced disease progression on or after platinum-containing therapy (e.g., cisplatin, carboplatin)? ❑ **Yes** ❑ **No**

Keytruda® Prior Authorization Request Form (Page 2 of 2)

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For melanoma, also answer the following:

Does the patient have unresectable or metastatic melanoma? ❑ **Yes** ❑ **No**

For microsatellite instability-high cancer, also answer the following:

Does the patient have unresectable or metastatic microsatellite instability high-cancer (MSI-H) or mismatch repair deficient solid tumors? ❑ **Yes** ❑ **No**

Has the patient experienced disease progression following prior treatment? ❑ **Yes** ❑ **No**

Has the patient exhausted all satisfactory alternative treatment options? ❑ **Yes** ❑ **No**

Does the patient have unresectable or metastatic microsatellite instability high-cancer (MSI-H) or mismatch repair deficient colorectal cancer? ❑ **Yes** ❑ **No**

Has the patient experienced progression following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan? ❑ **Yes** ❑ **No**

For non-small cell lung cancer (NSCLC), also answer the following:

Does the patient have metastatic NSCLC? ❑ **Yes** ❑ **No**

Select if the patient has tumors that express the following PD-L1 Tumor Proportion Score (TPS) as determined by an FDA-approved test:

- ❑ Greater than or equal to 1%
- ❑ Greater than or equal to 50%

Is Keytruda being used as first-line treatment? ❑ **Yes** ❑ **No**

Does the patient have epidermal growth factor receptor (EGFR) genomic tumor aberrations? ❑ **Yes** ❑ **No**

Does the patient have anaplastic lymphoma kinase (ALK) genomic tumor aberrations? ❑ **Yes** ❑ **No**

Has the patient experienced disease progression on or after platinum-containing chemotherapy? ❑ **Yes** ❑ **No**

Has the patient experienced disease progression on one anti-EGFR therapy [e.g., Gilotrif (afatinib), Iressa (gefitinib), Tarceva (erlotinib)]? ❑ **Yes** ❑ **No**

Has the patient experienced disease progression on one ALK inhibitor [e.g., Alecensa (alectinib), Xalkori (crizotinib), Zykadia (ceritinib)]? ❑ **Yes** ❑ **No**

Does the patient have non-squamous NSCLC? ❑ **Yes** ❑ **No**

If "yes" to the above question, will Keytruda be used in combination with pemetrexed and carboplatin? ❑ **Yes** ❑ **No**

For urothelial carcinoma, also answer the following:

Does the patient have locally advanced or metastatic urothelial carcinoma? ❑ **Yes** ❑ **No**

Is the patient eligible for cisplatin-containing chemotherapy? ❑ **Yes** ❑ **No**

Has the patient experienced disease progression during or following platinum-containing chemotherapy? ❑ **Yes** ❑ **No**

Has the patient experienced disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.