Indications for Use: (If this is a renewal proceed to question 25)

### Malignant Melanoma
1. Does patient have a diagnosis of unresectable or metastatic malignant melanoma?

### NSCLC
2. Does the patient have a diagnosis for metastatic non-small cell lung cancer (NSCLC) whose tumors express programmed death receptor-ligand1 (PD-L1) (TPS≥50%) as determined by an FDA approved test?
3. Does the patient have a diagnosis for NSCLS whose tumors express PD-L1 (TSP ≥1%) as determined by an FDA approved test?
4. Does the patient have a diagnosis of metastatic non-squamous NSCLC?
5. Is this first line treatment for patient with metastatic NSCLC with PD-L1 tumor expression without epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic aberrations?
6. Does the patient have disease progression of metastatic NSCLC with PD-L1 tumor expression on or after platinum-containing chemotherapy?
7. Does patient have EGFR or ALK genomic tumor aberrations?
8. If the patient has EGFR or ALK genomic tumor aberrations, are they being treated by FDA-approved therapy for these aberrations?
9. If the patient has EGFR or ALK genomic tumor aberrations and has previously treated aberrations with approved treatment, has disease progressed?
10. If the patient has metastatic non-squamous NSCLC, are they being treated in combination with pemetrexed and carboplatin?

### Head and Neck Squamous Cell Carcinoma
11. Does patient have recurrent or metastatic HNSCC with disease progression on or after platinum containing chemotherapy?

### Classical Hodgkin Lymphoma
12. Does the patient have a diagnosis of refractory classical lymphoma?
13. In patients with classical Hodgkin Lymphoma, has the patient relapsed after 3 or more prior lines of therapy?
**Urothelial Carcinoma**

14. Does the patient have a diagnosis of locally advanced or metastatic urothelial carcinoma that is ineligible for cisplatin-containing chemotherapy? ☐ ☐

15. Does the patient diagnosed with locally advanced or metastatic urothelial carcinoma have disease progression during or following platinum-containing treatment? ☐ ☐

16. Does the patient diagnosed with locally advanced or metastatic urothelial carcinoma have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy? ☐ ☐

**Microsatellite Instability-High Cancer**

17. Does the patient have a diagnosis of unresectable or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient solid tumors and the disease has progressed following prior treatment with no satisfactory alternative treatment options remaining? ☐ ☐

18. Does the patient have a diagnosis of unresectable or metastatic MSI-H or mismatch repair deficient colorectal cancer and the disease has progressed following treatment with fluoropyrimidine, oxaliplatin, and irinotecan? ☐ ☐

19. Is the patient a pediatric patient with MSI-H central nervous system cancer(s)? ☐ ☐

**Gastric Cancer**

20. Does the patient have a diagnosis of recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma whose tumors express PD-L1 (CPS ≥ 1%), as determined by and FDA-approved test? ☐ ☐

21. Does the patient have a diagnosis of recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma with disease progression on or after two or more prior lines of therapy, including fluoropyrimidine- and platinum-containing chemotherapy, and if appropriate HER2/neu targeted therapy? ☐ ☐

**General**

22. Is the prescriber an oncologist or is consulting with an oncologist? ☐ ☐

23. Has the patient had baseline thyroid and liver function testing (TSH, AST, ALT, total bilirubin) completed? ☐ ☐

24. Does the patient have a known allergy to pembrolizumab or any other component of Keytruda? ☐ ☐

**Renewal**

25. Is there evidence of positive clinical response without disease progression or unacceptable toxicity? ☐ ☐

**Prescription will be dispensed at (circle one):** Provider Office ☐ Network Pharmacy ☐

If patient meets criteria: **Initial approval:** 12 weeks **Renewal Period:** 36 months

Dose: _________ Frequency: _________ Duration of Therapy: _________

________________________  ________________________________
**Prescriber’s Signature**  **Date**

*By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.*