Keytruda
(pembrolizumab)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Keytruda 100mg/4ml vial

Directions for use: Quantity: Duration of therapy: J-Code:

Patient's current weight: ICD10:

Is this new start or continuation of therapy?
☐ new start
☐ continuation of therapy

(if continuation of therapy) Is your patient responding to therapy or is your patient NOT experiencing disease progression while on this medication? ☐ Yes ☐ No

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? Yes ☐ No ☐

Diagnosis

☐ adrenocortical carcinoma
☐ ampullary adenocarcinoma
☐ anal carcinoma
☐ alveolar soft part sarcoma (ASPS)
☐ Biliary tract carcinoma (BTC)
☐ breast cancer
☐ brain metastases from melanoma or non-small cell lung cancer (NSCLC)
☐ cervical cancer
☐ chordoma
☐ chronic lymphocytic leukemia/small lymphocytic lymphoma for histologic (Richter's) transformation to diffuse large B-cell lymphoma
☐ chondrosarcoma
☐ cutaneous angiosarcoma
☐ cutaneous squamous cell carcinoma (cSCC)
☐ endometrial carcinoma
☐ esophageal or gastroesophageal (GEJ) (tumors with epicenter 1-5 cm above the GEJ) carcinoma
☐ Ewing's sarcoma
☐ extranodal NK/T-Cell Lymphoma (nasal type)
☐ gastric/gastroesophageal junction adenocarcinoma
☐ gestational trophoblastic neoplasia (GTN)
☐ hepatocellular carcinoma (HCC)
☐ Hodgkin lymphoma (HL)
☐ Kaposi sarcoma (KS*)*
☐ malignant pleural mesothelioma (MPM)
☐ melanoma
☐ Merkel cell carcinoma (MCC)
☐ mycosis fungoides (MF)/Sezary Syndrome (SS)
☐ myxofibrosarcoma
☐ non-muscle invasive bladder cancer (NMIBC)
☐ non-small cell lung cancer (NSCLC)
☐ osteosarcoma
☐ ovarian carcinoma
☐ pancreatic adenocarcinoma
☐ primary mediastinal large B-cell lymphoma (PMBCL)
☐ renal cell carcinoma (RCC)
☐ solid tumors
☐ thyroid carcinoma
☐ small cell lung cancer (SCLC)
☐ squamous cell carcinoma of the esophagus (ESCC)
☐ squamous cell carcinoma of the head and neck (SCCHN)
☐ T-cell lymphoma
☐ thymic carcinoma
☐ thyroid carcinoma (includes Anaplastic Thyroid Carcinoma)
☐ other solid tumors
☐ undifferentiated pleomorphic sarcoma (UPS)
☐ undifferentiated sarcomas of retroperitoneal/intra-abdominal and extremity/body well/head/neck
☐ urothelial carcinoma (UCC, transitional cell carcinoma [TCC])
☐ other *(please specify):*

Clinical Information

****This drug requires supportive documentation (i.e. genetic testing, chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.**

Does your patient have a microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) solid tumor? Yes ☐ No ☐

(if yes) Does your patient have colorectal cancer (CRC)? Yes ☐ No ☐

(if not CRC) Which of the following best describes your patient's diagnosis?

☐ biliary tract carcinoma (BTC)
☐ breast cancer
☐ chondrosarcoma
☐ endometrial carcinoma
☐ Ewing sarcoma
☐ osteosarcoma
☐ ovarian carcinoma
☐ pancreatic adenocarcinoma
☐ solid tumors
☐ thyroid carcinoma
☐ other

(if MSI-H/dMMR, NOT BTC, CRC, ovarian, pancreatic, thyroid, or endometrial) Does your patient have unresectable or metastatic disease? Yes ☐ No ☐

(if MSI-H/dMMR, NOT BTC, CRC, ovarian, pancreatic, thyroid, or endometrial) Has your patient previously been treated with any therapy for this diagnosis?

Yes ☐ No ☐

(if yes) Did you patient have disease progression with the previous treatment? Yes ☐ No ☐

(if MSI-H/dMMR NOT BTC, CRC, ovarian, pancreatic, thyroid, or endometrial) Are there any satisfactory alternative options available for treatment?

Yes ☐ No ☐

(if anal carcinoma, ASPS, BTC, brain mets, breast [MSI-H/dMMR or TMB-H], chondrosarcoma, chordoma, CRC, cutaneous angiosarcoma, Ewing, GTN, HL, KS, MPM, myxofibrosarcoma, NSCLC, osteosarcoma, thymic carcinoma, undifferentiated sarcomas or UPS) Is this medication being used as single-agent therapy? Yes ☐ No ☐

(if adrenocortical carcinoma or SCLC) Does your patient have metastatic disease? Yes ☐ No ☐

(if anal carcinoma, MPM, or Extranodal NK/T-Cell Lymphoma [nasal type], or thymic carcinoma) Has your patient previously received any chemotherapy for this diagnosis? Yes ☐ No ☐

(if cervical) Has the patient already received any type of treatment for this diagnosis?

- ☐ Yes and prior treatment included chemotherapy
- ☐ Yes and prior treatment did NOT include chemotherapy
- ☐ No

(if cervical) Will the patient also be receiving chemoradiotherapy (CRT)? Yes ☐ No ☐

(if yes) Does the patient have FIGO 2014 Stage III-IVA disease? Yes ☐ No ☐

(if breast cancer) Does your patient have tumor mutational burden-high (TMB-H) tumors with 10 or more mutations per megabase? Yes ☐ No ☐

(if chondrosarcoma, chordoma, Ewing sarcoma, osteosarcoma, solid tumors [not MSI-H/dMMR]) Does your patient have tissue mutation burden-high (TMB-H) tumors with 10 or more mutations per megabase? Yes ☐ No ☐

(if breast, chordoma, solid tumors OR chondrosarcoma, osteosarcoma [not MSI-H/dMMR]) Does your patient have unresectable or metastatic disease? Yes ☐ No ☐

(if breast, chordoma, solid tumors OR chondrosarcoma, osteosarcoma [not MSI-H/dMMR]) Has your patient previously been treated with any therapy for this diagnosis? Yes ☐ No ☐

(if yes) Did your patient have disease progression with the previous treatment? Yes ☐ No ☐

(if breast, chordoma, solid tumors OR chondrosarcoma, osteosarcoma [not MSI-H/dMMR]) Are there any satisfactory alternative options available for treatment? Yes ☐ No ☐

(if breast cancer, not TMB-H) Does the patient have high-risk early-stage triple negative breast cancer (TNBC)? Yes ☐ No ☐

(if high-risk early-stage TNBC) Which of the following best describes how this medication will be used for this patient?

- ☐ as adjuvant therapy
- ☐ as neoadjuvant therapy
- ☐ other

(if adjuvant) Is this medication to be given as single-agent therapy after surgery? Yes ☐ No ☐

(if neoadjuvant) Is this medication to be given in combination with chemotherapy? Yes ☐ No ☐

(if breast, NOT TMB-H or MSI-H/dMMR) Does your patient have PD-L1 positive (combined positive [CPS] greater than or equal to 10), triple negative disease? Yes ☐ No ☐

(if PD-L1+, triple negative) Does your patient have recurrent or stage IV (M1) disease? Yes ☐ No ☐

(if PD-L1+, triple negative and recurrent or stage IV) Is/Will this medication (be)ing used in combination with either albumin-bound paclitaxel, paclitaxel, OR gemcitabine with carboplatin? Yes ☐ No ☐

(if PD-L1+, triple negative and recurrent or stage IV) How is this medication being used in this patient?

- ☐ as preferred first-line therapy
- ☐ as second or subsequent lines of therapy
- ☐ unknown

(if second or subsequent lines of therapy) Has a PD-L1 inhibitor previously been used in this patient? Yes ☐ No ☐

(if not recurrent or stage IV [M1] disease) Does your patient have locally recurrent unresectable or metastatic disease? Yes ☐ No ☐

(if yes) Is/will this medication be(ing) used in combination with chemotherapy? Yes ☐ No ☐

(if cervical and received chemo before) Did your patient have disease progression while on or after chemotherapy? Yes ☐ No ☐

(if CRC) Does your patient have unresectable, advanced, or metastatic disease? Yes ☐ No ☐

(if CRC) Which of the following best describes how this medication is being used in your patient?
- ☐ first-line therapy or initial treatment in patient that are not appropriate for intensive therapy
- ☐ subsequent therapy (has previously used other medication for this diagnosis)
- ☐ unknown

(if subsequent) Has your patient been previously treated with an oxaliplatin-based chemotherapy regimen? Yes ☐ No ☐

(if esophageal or GEJ carcinoma) Does your patient have metastatic or locally advanced disease? Yes ☐ No ☐

(if esophageal or GEJ carcinoma) Is the disease amenable to surgical resection or definitive chemoradiation? Yes ☐ No ☐

(if esophageal or GEJ carcinoma) How is the requested medication to be used in this patient?
- ☐ in combination with platinum (carboplatin, cisplatin)- and fluoropyrimidine (capecitabine [Xeloda], fluorouracil [5-FU, Adrucil])-based chemotherapy
- ☐ as a single agent
- ☐ neither of the above

(if endometrial and dMMR/MSI-H positive) How will this medication be used?
- ☐ as a single agent therapy
- ☐ In combination with carboplatin and paclitaxel, followed by single agent therapy
- ☐ Other

(if endometrial and dMMR/MSI-H negative) How will this medication be used?
- ☐ In combination with lenvatinib (Lenvima)
- ☐ In combination with carboplatin and paclitaxel, followed by single agent therapy
- ☐ Other

(if endometrial single agent or with Lenvima, ESCC OR esophageal or GEJ carcinoma single agent) Has this patient been treated with any systemic therapy for this diagnosis BEFORE this medication? Yes ☐ No ☐

(if esophageal or GEJ carcinoma, single agent) Does the patient have tumors of squamous cell histology? Yes ☐ No ☐

(if esophageal or GEJ carcinoma, single agent) Does the patient have tumors that express PD-L1? Note: You may answer yes if there is an indication that the patient has a CPS (combined positive score) greater than or equal to 1 on the immunohistochemistry (IHC) results. Yes ☐ No ☐

(if endometrial single agent or with Lenvima or ESCC AND previous systemic therapy) Did your patient have progression of disease after prior systemic therapy? Yes ☐ No ☐

(if endometrial single agent or with Lenvima or RCC) Does your patient have advanced disease? Yes ☐ No ☐

(if endometrial [not MSI-H/dMMR]) Has your patient undergone immunohistochemistry (IHC) or microsatellite instability (MSI) testing)? Yes ☐ No ☐

(if yes) What were the results?
- ☐ deficient mismatch repair (dMMR) or microsatellite instability-high (MSI-H)
- ☐ proficicent mismatch repair (pMMR) or microsatellite instability-low or stable (MSI-low or MSI-stable)

(if endometrial single agent or with Lenvima) Is your patient a candidate for curative surgery or radiation? Yes ☐ No ☐

(if endometrial and with carboplatin and paclitaxel, followed by single agent) Does your patient have primary advanced or recurrent disease? Yes ☐ No ☐

(if ESCC) Does your patient have recurrent, locally advanced or metastatic disease? Yes ☐ No ☐

(if MCC or gastric/gastroesophageal junction adenocarcinoma) Does your patient have recurrent locally advanced or metastatic disease? Yes ☐ No ☐

(if gastric/gastroesophageal junction adenocarcinoma) Does your patient have tumors that express PD-L1 as determined by an FDA-approved test? Notes: You may answer yes if there is an indication that the patient has a CPS (combined positive score) greater than or equal to 1 on immunohistochemistry (IHC) results. Yes ☐ No ☐

(if gastric/GEJ adenocarcinoma, no PD-L1) Does your patient have HER2 positive disease? Yes ☐ No ☐

(if gastric/GEJ adenocarcinoma [HER2 positive] OR RCC) Is this the first treatment your patient has received for this diagnosis? Yes ☐ No ☐

(if gastric/GEJ adenocarcinoma [HER2 positive]) Is/Will this medication be(ing) used in combination with trastuzumab (Herceptin, Herzuma, Kanjinti, Ogivri, Ontruzant, Trazimera), fluoropyrimidine (capecitabine [Xeloda], fluorouracil [5-FU, Adrucil])- and platinum-containing (carboplatin, cisplatin) chemotherapy? Yes ☐ No ☐

(if HCC) Has your patient previously been treated with sorafenib (Nexavar)? Yes ☐ No ☐

(if HL) Which of the following applies to your patient?
- ☐ patient is older than 60 years
- ☐ patient is 18-60 years
- ☐ patient is less than 18 years

(if HL and 60+) Is this medication being used as palliative therapy? Yes ☐ No ☐

(if HL and 18-60 OR not palliative therapy) Does this patient have relapsed or refractory disease? Yes ☐ No ☐

(if HL and under 18) Does your patient have relapsed or refractory disease? Yes ☐ No ☐

(if HL and under 18) Has your patient been previously treated with a chemotherapy regimen? Yes ☐ No ☐

(if HL and under 18) Was your patient heavily pretreated with platinum or anthracycline-based chemotherapy? Yes ☐ No ☐

(if not heavily pretreated) Does your patient have decreased cardiac function? Yes ☐ No ☐

(if no decreased cardiac function) Has your patient relapsed after 2 or more prior lines of therapy? Yes ☐ No ☐

(if melanoma, no brain mets) Does your patient have unresectable or metastatic disease? Yes ☐ No ☐

(if melanoma, no brain mets and not unresectable or metastatic) Is this medication being used for adjuvant treatment? Yes ☐ No ☐

(if melanoma, no brain mets and not unresectable or metastatic and adjuvant treatment) Is this medication being used for disease with involvement of lymph node(s) following complete resection? Yes ☐ No ☐

(if melanoma, no brain mets and not unresectable or metastatic and adjuvant treatment) Is this medication being used for stage IIB or stage IIIC disease following complete resection? Yes ☐ No ☐

(if cervical w/prior chemo or cSCC) Does your patient have recurrent or metastatic disease? Yes ☐ No ☐

(if cSCC) Is the disease curable by surgery or radiation? Yes ☐ No ☐

(if SCCHN) Does your patient have metastatic or unresectable, recurrent disease? Yes ☐ No ☐

(
if SCCHN) Is this medication being used as first-line therapy? Yes ☐ No ☐

(if first-line) Will this medication be used in combination with platinum-containing chemotherapy (carboplatin, cisplatin) and fluorouracil (FU)? Yes ☐ No ☐

(if not in combo with platinum and FU chemo) Is your patient's cancer expressing PD-L1? Note: You may answer yes if there is an indication that the patient has a CPS (combined positive score) greater than or equal to 1 on immunohistochemistry (IHC) results. Yes ☐ No ☐

(if not first-line therapy) Did your patient have disease progression on or after treatment with platinum-containing chemotherapy (carboplatin, cisplatin)? Yes ☐ No ☐

(if not PD-L1 or no progression on platinum) Do either of the following situations apply to your patient?
- ☐ locoregional recurrence
- ☐ unfit for surgery
- ☐ neither of the above

(if neither of the above) What is your patient's performance status (PS)?
- ☐ PS 0
- ☐ PS 1
- ☐ PS 2
- ☐ PS 3
- ☐ PS 4
- ☐ unknown

(if PS 0-2) Has your patient received prior radiation therapy? Yes ☐ No ☐

(

if prior radiation therapy) Does your patient have either of the following?

- ☐ locoregional recurrence
- ☐ second primary malignancy
- ☐ neither of the above

(if PD-L1 or disease progression w/platinum) Is this medication being used as single-agent therapy? Yes ☐ No ☐

(if NSCLC w/o brain mets) Is this medication being used as adjunctive therapy following resection and platinum-containing chemotherapy? Yes ☐ No ☐

(if NSCLC, adjunctive therapy) Does the patient have stage IB (T2a greater than or equal to 4 cm), II, or IIIA disease? Yes ☐ No ☐

(if stage IB, II, or IIIA NSCLC) Will this medication be the only one used at this time for this diagnosis? Yes ☐ No ☐

(if NSCLC w/o brain mets; not adjunctive; not stage IB, II, IIIA; not single agent; not adult patient) Is this medication being used for first-line therapy or subsequent (after-first line) therapy?

- ☐ first-line therapy
- ☐ subsequent therapy
- ☐ unknown

(if anal carcinoma or NSCLC 1st line) Does your patient have metastatic disease? Yes ☐ No ☐

(if first-line, metastatic NSCLC) Which subtype of NSCLC does your patient have?

- ☐ non-squamous (includes adenocarcinoma, large cell carcinoma, other types)
- ☐ squamous
- ☐ unknown

(if squamous) Is/Was this medication (being) used in combination with carboplatin AND either paclitaxel or Abraxane for the first 4 cycles of therapy? Yes ☐ No ☐

(if cervical, ESCC or non-squamous NSCLC Is your patient's cancer expressing PD-L1? Note: You may answer yes if there is an indication that the patient has a CPS (combined positive score) greater than or equal to 1 on the immunohistochemistry (IHC) results. Yes ☐ No ☐

(if non-squamous NSCLC) Is/Was this medication (being) used in combination with Alimta (pemetrexed) and carboplatin for the first 4 cycles of therapy? Yes ☐ No ☐

(if unknown subtype OR squamous NSCLC and not in combo w/carboplatin and paclitaxel or Abraxane) Do your patient’s tumors express PD-L1? Note: You may answer yes if there is an indication that the patient has a CPS (combined positive score) greater than or equal to 1 on the immunohistochemistry (IHC) results. Yes ☐ No ☐

(if first-line NSCLC, not in combo w/carboplatin and paclitaxel or Abraxane OR Alimta and carboplatin, PD-L1+) Which applies to your patient’s cancer?

- ☐ tumors are ALK-negative, EGFR-negative, AND ROS1-negative
- ☐ tumors are ALK-positive OR EGFR-positive
- ☐ tumors are ALK-negative, EGFR-negative AND either ROS1-positive or unknown
- ☐ unknown/genetic testing not done

(if ALK-negative and EGFR-negative and either ROS1-positive or unknown NSCLC) What is your patient’s cancer stage?

- ☐ stage 1 (I)
- ☐ stage 2 (II)
- ☐ stage 3 (III)
- ☐ stage 4 (IV)
- ☐ unknown

(if no brain mets NSCLC and subsequent therapy) Does your patient have metastatic disease? Yes ☐ No ☐

(if metastatic NSCLC subsequent therapy) Is your patient’s cancer expressing PD-L1? Note: You may answer yes if there is an indication that the patient has a CPS (combined positive score) greater than or equal to 1 on the immunohistochemistry (IHC) results. Yes ☐ No ☐

(if metastatic NSCLC subsequent therapy, PD-L1+) Which applies to your patient’s cancer?

- ☐ tumors are ALK-negative, EGFR-negative AND ROS1-negative
- ☐ tumors are ALK-positive, EGFR-positive, or ROS1-positive
- ☐ unknown/genetic testing not done

(if all negative) Had your patient previously received carboplatin or cisplatin chemotherapy? Yes ☐ No ☐

(if positive) Does your patient have ALK-positive disease? Yes ☐ No ☐

(if ALK-positive) Has your patient previously been treated with either alectinib (Alecensa), ceritinib (Zykadia), or crizotinib (Xalkori)? Yes ☐ No ☐

(if positive) Does your patient have EGFR-positive disease? Yes ☐ No ☐

(if EGFR-positive) Has your patient previously been treated with any of the following: afatinib (Gilotrif), erlotinib (Tarceva), gefitinib (Iressa), or osimertinib (Tagrisso)? Yes ☐ No ☐

(if positive) Does your patient have ROS1-positive disease? Yes ☐ No ☐

(if ROS1-pos) Had your patient previously been treated with crizotinib (Xalkori)? Yes ☐ No ☐

(if NOT metastatic, first-line NSCLC) Is your patient's cancer expressing PD-L1? Note: You may answer yes if there is an indication that the patient has a CPS (combined positive score) greater than or equal to 1 on the immunohistochemistry (IHC) results. Yes ☐ No ☐

(if expressing PD-L1) What is your patient's cancer stage?
☐ stage 1 (I)
☐ stage 2 (II)
☐ stage 3 (III)
☐ stage 4 (IV)
☐ unknown

(if stage III) Which applies to your patient's cancer?
☐ Tumors are ALK-negative AND EFGR-negative
☐ Tumors are ALK-positive, EGFR-negative
☐ Tumors are ALK-negative, EGFR-positive
☐ Tumors are ALK-positive AND EGFR-positive
☐ unknown/genetic testing not done

(if ALK and EGFR negative) Is your patient a candidate for surgical resection or definitive chemoradiation? Yes ☐ No ☐

(if CLL/SLL) Does your patient have the del(17p)/TP53 mutation? Yes ☐ No ☐

(if CLL/SLL) Is your patient refractory to chemotherapy and unable to receive chemoimmunotherapy? Yes ☐ No ☐

(if GTN) Does your patient have recurrent or progressive disease? Yes ☐ No ☐

(if GTN) Was your patient previously treated with a platinum/etoposide-containing regimen? Yes ☐ No ☐

(if NMIBC) Is your patient's disease considered high-risk, with carcinoma in situ (CIS)? Yes ☐ No ☐

(if NMIBC) Has your patient tried Bacillus Calmette-Guerin (BCG) treatment? Yes ☐ No ☐

(if yes) Was your patient considered unresponsive to treatment with Bacillus Calmette-Guerin (BCG)? Yes ☐ No ☐

(if no) Please explain why BCG was not tried. _____

(if NMIBC) Does your patient have papillary tumors? Yes ☐ No ☐

(if NMIBC) Is your patient eligible to undergo cystectomy?
☐ No
☐ Yes, but have elected NOT to undergo cystectomy
☐ Yes

(if PMBCL, T-cell lymphoma, Extranodal NK/T-Cell Lymphoma [nasal type]) Does your patient have relapsed or refractory disease? Yes ☐ No ☐

(if RCC) Will your patient use this medication in combination with axitinib (Inlyta) or lenvatinib (Lenvima))? Yes ☐ No ☐

(if RCC) Will your patient use this medication as adjuvant treatment? Yes ☐ No ☐

(if RCC) Is your patient at intermediate-high or high risk of recurrence? Yes ☐ No ☐

(if RCC) Has the patient undergone nephrectomy (or undergone nephrectomy and resection of metastatic lesions)? Yes ☐ No ☐

(if thymic carcinoma) Which of the following applies to your patient?
☐ unresectable disease following first-line chemotherapy for potentially resectable locally advanced disease, solitary metastasis, or ipsilateral pleural metastasis
☐ extrathoracic metastatic disease
☐ neither of the above

(if UCC) Does your patient have locally advanced or metastatic disease? Yes ☐ No ☐

(if SCLC or UCC) Did your patient try platinum-based chemotherapy (carboplatin, cisplatin) and have disease progression during or after treatment with it? Yes ☐ No ☐

(if no) Is your patient able to use a cisplatin-containing chemotherapy regimen? Yes ☐ No ☐

(if KS) Does the patient have relapsed/refractory advanced cutaneous, oral, visceral, or nodal disease? Yes ☐ No ☐

(if KS) Did the patient experience disease progression on -or- did the patient not respond to- first-line systemic therapy? Yes ☐ No ☐

(if BTC [MSI-H/dMMR]) How is this medication being used in this patient?
- ☐ Primary treatment
- ☐ Subsequent treatment

(if BTC [not MSI-H/dMMR]) Has the patient tried other therapies for this diagnosis before this medication? Yes ☐ No ☐

(if BTC, subsequent therapy) Did the patient experience disease progression on or after systemic treatment? Yes ☐ No ☐

(if BTC) Does the patient have unresectable or resected gross residual disease? Yes ☐ No ☐

(if no) Does the patient have metastatic disease? Yes ☐ No ☐

(if BTC, not MSI-H/dMMR) Does the patient have tumor mutational burden-high (TMB-H) disease? Yes ☐ No ☐

(if BTC, not MSI-H/dMMR) Has the patient previously been treated with a checkpoint inhibitor? Yes ☐ No ☐

(if ovarian, pancreatic, thyroid not MSI-H/dMMR) Does the patient have tumor mutational burden-high (TMB-H) disease? Yes ☐ No ☐

(if thyroid carcinoma) What type of thyroid carcinoma does your patient have?
- ☐ Anaplastic thyroid carcinoma (ATC)
- ☐ Follicular carcinoma
- ☐ Hürthle cell carcinoma
- ☐ oncocytic and papillary carcinoma
- ☐ None of the above or Unknown

(if ATC) Will this medication be the only one used at this time for this diagnosis? Yes ☐ No ☐

(if no) Will this medication be used in combination with lenvatinib? Yes ☐ No ☐

(if not single agent) Does your patient have stage IVC (metastatic) disease? Yes ☐ No ☐

(if ATC) How is the requested medication to be used in this patient?
- ☐ as aggressive first-line therapy
- ☐ as second-line therapy
- ☐ neither of the above

(if thyroid TMB-H MSI-H dMMR) Does your patient have locally recurrent, metastatic, or progressive disease? Yes ☐ No ☐

(if thyroid TMB-H MSI-H dMMR) Is your patient's disease radioactive iodine-refractory? Yes ☐ No ☐

(if pancreatic adenocarcinoma) Does your patient have locally advanced or metastatic disease? Yes ☐ No ☐
- ☐ locally advanced
- ☐ metastatic
- ☐ neither of the above

(if pancreatic adenocarcinoma) What is your patient's performance status?
- ☐ PS 0
- ☐ PS 1
- ☐ PS 2
- ☐ PS 3
- ☐ PS 4
- ☐ None of the above or unknown

(if pancreatic adenocarcinoma) Will this medication be the only one used at this time for this diagnosis? Yes ☐ No ☐

(if pancreatic adenocarcinoma) Is this medication being used for first-line therapy or subsequent (after-first line) therapy?
- ☐ first-line therapy
- ☐ subsequent therapy

(if subsequent) Did the patient experience disease progression? Yes ☐ No ☐

(if ovarian) Does your patient have persistent or recurrent disease? Yes ☐ No ☐

(if yes) Will this medication be the only one used at this time for this diagnosis? Yes ☐ No ☐

(if ovarian) Will your patient use this medication in combination with oral cyclophosphamide and bevacizumab? Yes ☐ No ☐

(if yes) Does your patient have platinum-resistant disease? Yes ☐ No ☐

(if ovarian and combo) Does your patient have serially rising CA-125? Yes ☐ No ☐

(if yes) Did your patient previously receive chemotherapy? Yes ☐ No ☐

(if ovarian and combo) Which of the following applies to your patient's treatment?

☐ for progression on primary, maintenance, or recurrence therapy
☐ for stable or persistent disease (if not on maintenance therapy)
☐ for complete remission and relapse less than 6 months after completing chemotherapy
☐ none of the above

Additional Pertinent Information: *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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