Prescriber Criteria Form Keytruda QLEX 2026 PA Fax 7241-A v1 010126.docx Keytruda QLEX (pembrolizumab and berahyaluronidase alfa-pmph) 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 QLEX (pembrolizumab and berahyaluronidase alfa-pmph).

Drug Name: Keytruda QLEX (pembrolizumab and berahyaluronidase alfa-pmph)

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 colorectal cancer? [If no, then skip to question 3.]	Yes	No
2	Does the patient have either of the following: A) microsatellite instability-high (MSI-H) disease, B) mismatch repair deficient (dMMR) disease? [No further questions.]	Yes	No
3	Does the patient have a diagnosis of gastric, gastroesophageal junction, or esophageal cancer? [If yes, then no further questions.]	Yes	No
4	Does the patient have a diagnosis of cervical cancer? [If yes, then no further questions.]	Yes	No
5	Does the patient have a diagnosis of solid tumor 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 patient has no satisfactory alternative treatment options? [If yes, then no further questions.]	Yes	No
6	Does the patient have a diagnosis of melanoma? [If yes, then no further questions.]	Yes	No

7	Does the patient have a diagnosis of non-small cell lung cancer? [If yes, then no further questions.]	Yes	No
8	Does the patient have a diagnosis of head and neck squamous cell cancer? [If yes, then no further questions.]	Yes	No
9	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 11.]	Yes	No
10	Is the patient ineligible for or has the patient elected not to undergo cystectomy? [No further questions.]	Yes	No
11	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
12	Does the patient have a diagnosis of hepatocellular carcinoma? [If yes, then no further questions.]	Yes	No
13	Does the patient have a diagnosis of renal cell carcinoma? [If yes, then no further questions.]	Yes	No
14	Does the patient have a diagnosis of cutaneous squamous cell carcinoma (cSCC) that meets ONE of the following: A) the disease is recurrent or metastatic, B) the disease is locally advanced and is not curable by surgery or radiation? [If yes, then no further questions.]	Yes	No
15	Does the patient have a diagnosis of triple negative breast cancer? [If yes, then no further questions.]	Yes	No
16	Does the patient have a diagnosis of Merkel cell carcinoma? [If yes, then no further questions.]	Yes	No
17	Does the patient have a diagnosis of endometrial carcinoma? [If yes, then no further questions.]	Yes	No
18	Does the patient have any of the following diagnoses: A) biliary tract cancer, B) pleural, pericardial, tunica vaginalis, or peritoneal mesothelioma, C) thymic carcinoma?	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:**_____