Precertification Requested By: Olivia Phone: (913) 498-6036 Fax:

A. PATIENT INFORMATION

First Name: Larry	Last Name: [redacted]		DOB: 12/09/1946	
Address: 21619 S Peculiar Dr		City: Peculiar	State: MO	ZIP: 64078
Home Phone: (816) 779-6094	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: 142.42 lbs or ____ kgs	Patient Height: 64 inches or ____ cms		Allergies: ampicillin	

B. INSURANCE INFORMATION

[redacted]	Does patient have other coverage? ☐ Yes ☑ No
Group #: 811303-10-512	If yes, provide ID#: Carrier Name:
Insured: Same	Insured:

Medicare: ☐ Yes ☑ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name: Joseph		Last Name: Stilwill		(Check One): ☑ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address: 12140 Nall Ave Suite 200			City: Overland Park	State: KS	ZIP: 66209
Phone: (913) 498-6036	Fax: (913) 498-6606	St Lic #: 04-35975	NPI #: 1750355871	DEA #: FS3482407	UPIN:
Provider Email:		Office Contact Name: Olivia		Phone:	

Specialty *(Check one)*: ☑ **Oncologist** ☐ **Other:**

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
- ☐ Self-administered ☐ Physician's Office
- ☑ Outpatient Infusion Center Phone:
  - Center Name: Menorah Medical Center buy/bill
- ☐ Home Infusion Center Phone:
  - Agency Name:
- ☐ Administration code(s) (CPT):
- Address:

Dispensing Provider/Pharmacy: *Patient Selected choice*
- ☐ Physician's Office ☐ Retail Pharmacy
- ☐ Specialty Pharmacy ☑ Other:
- Name: Menorah Medical Center (buy/bill)
- Address: 5721 W 119th Overland Park, Ks 66209
- Phone: (913) 498-6000 Fax: (913) 498-6606
- **TIN:** 481301826 PIN:

E. PRODUCT INFORMATION

Request is for: Keytruda (pembrolizumab)

Dose: 200 mg **Frequency:** every 3 weeks, 4 cycles

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ☐ C34.91 **Secondary ICD Code:** C79.51 **Other ICD Code:**

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):

Please list *all* additional medications that will be used as part of this treatment regimen (This includes supportive care agents such as anti-emetics, growth factors, etc. A copy of the complete order may be submitted in lieu of listing out each treatment):

Medication: Keytruda	Dose: 200 mg	Frequency: every 3 weeks	
Medication: Paraplatin	Dose: 320 mg	Frequency: every 3 weeks	
Medication: Abraxance	Dose: 100 mg	Frequency: every 3 weeks	
Medication: Decadron	Dose: 10mg	Frequency: every 3 weeks	
Medication: Zofran	Dose: 16 mg	Frequency: every 3 weeks	

☐ Yes ☑ No Has the patient experienced disease progression while receiving another programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor (e.g., Opdivo (nivolumab), Tecentriq (atezolizumab), Keytruda (pembrolizumab), Bavencio (avelumab), or Imfinzi (durvalumab))?

☐ **Anal carcinoma**

☐ Yes ☐ No Will Keytruda (pembrolizumab) be used as a single agent?

Please indicate the clinical setting in which the requested drug will be used: ☐ Metastatic disease ☐ Other, please explain:

Please select the place in therapy in which the requested drug will be used: ☐ First-line treatment ☐ Second-line or subsequent treatment