Clinical Policy: Pembrolizumab, Pembrolizumab/Berahyaluronidase Alfa-pmph (Keytruda, Keytruda Qlex)

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Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Pembrolizumab (Keytruda®) is a programmed death receptor-1 (PD-1)-blocking antibody. Pembrolizumab/berahyaluronidase alfa-pmph (Keytruda Qlex™) is a combination of pembrolizumab and berahyaluronidase alfa, an endoglycosidase.

FDA Approved Indication(s)

Indication	Adults	Pediatrics	Keytruda	Keytruda Qlex
Melanoma	X	X	X	X
Non-small cell lung cancer	X		X	X
Malignant pleural mesothelioma (MPM)	X		X	X
Head and neck squamous cell carcinoma (HNSCC)	X		X	X
Classical Hodgkin lymphoma	X	X	X	
Primary mediastinal large B-cell lymphoma	X	X	X	
Urothelial cancer	X		X	X
Microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) cancer *(First-line treatment for colorectal cancer limited to adults.)*	X	X	X	X
Gastric cancer	X		X	X
Esophageal cancer	X		X	X
Cervical cancer	X		X	X
Hepatocellular carcinoma	X		X	X
Biliary tract cancer	X		X	X
Merkel cell carcinoma	X	X	X	X
Renal cell carcinoma	X		X	X
Endometrial carcinoma	X		X	X
Tumor mutational burden-high (TMB-H) cancer	X	X *(excludes CNS tumor)*	X	X
Cutaneous squamous cell carcinoma	X		X	X
Triple-negative breast cancer (TNBC)	X		X	X
Ovarian cancer	X		X	X

**If a solid tumor is characterized as MSI-H/dMMR or TMB-H, see criteria at Sections I.H or I.P respectively*

Keytruda and Keytruda Qlex are indicated:

- **Melanoma**
  - For the treatment of patients with unresectable or metastatic melanoma.
  - For the adjuvant treatment of adult and pediatric (12 years and older) patients with Stage IIB, IIC, or III melanoma following complete resection.
- **Non-small cell lung cancer (NSCLC)**
  - In combination with pemetrexed and platinum chemotherapy, as first-line treatment of adult patients with metastatic nonsquamous NSCLC, with no EGFR or ALK genomic tumor aberrations.
  - In combination with carboplatin and either paclitaxel or paclitaxel protein-bound, as first-line treatment of adult patients with metastatic squamous NSCLC.
  - As a single agent for the first-line treatment of adult patients with NSCLC expressing PD-L1 [Tumor Proportion Score (TPS) ≥ 1%] as determined by an FDA-approved test, with no EGFR or ALK genomic tumor aberrations, and is:
    - Stage III where patients are not candidates for surgical resection or definitive chemoradiation, or
    - Metastatic.
  - As a single agent for the treatment of adult patients with metastatic NSCLC whose tumors express PD-L1 (TPS ≥ 1%) as determined by an FDA-approved test, with disease progression on or after platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving Keytruda or Keytruda Qlex.
  - For the treatment of adult patients with resectable (tumors ≥ 4 cm or node positive) NSCLC in combination with platinum-containing chemotherapy as neoadjuvant treatment, and then continued as a single agent as adjuvant treatment after surgery.
  - As a single agent for the adjuvant treatment following resection and platinum-based chemotherapy for adult patients with Stage IB (T2a ≥ 4 cm), II, or IIIA NSCLC.
- **Malignant pleural mesothelioma (MPM)**
  - In combination with pemetrexed and platinum chemotherapy, as first-line treatment of adult patients with unresectable advanced or metastatic MPM.
- **Head and neck squamous cell cancer (HNSCC)**
  - For the treatment of adult patients with resectable locally advanced HNSCC whose tumors express PD-L1 (Combined Positive Score [CPS] ≥ 1) as determined by an FDA-approved test, as a single agent as neoadjuvant treatment, continued as adjuvant treatment in combination with radiotherapy (RT) with or without cisplatin and then as a single agent.
  - In combination with platinum and fluorouracil (FU) for the first-line treatment of adult patients with metastatic or with unresectable, recurrent HNSCC.
  - As a single agent for the first line treatment of adult patients with metastatic or with unresectable, recurrent HNSCC whose tumors express PD-L1 (CPS ≥ 1) as determined by an FDA-approved test.
  - As a single agent for the treatment of adult patients with recurrent or metastatic HNSCC with disease progression on or after platinum containing chemotherapy.

- **Urothelial cancer**
  - In combination with enfortumab vedotin-ejfv for the treatment of adult patients with locally advanced or metastatic urothelial cancer.
  - As a single agent for the treatment of adult patients with locally advanced or metastatic urothelial carcinoma:
    - who are not eligible for any platinum-containing chemotherapy, or
    - who have disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.
  - In combination with enfortumab vedotin-ejfv, as neoadjuvant treatment and then continued after cystectomy as adjuvant treatment of adult patients with muscle invasive bladder cancer (MIBC).
  - As a single agent for the treatment of patients with Bacillus Calmette-Guerin (BCG)-unresponsive, high-risk, non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors who are ineligible for or have elected not to undergo cystectomy.
- **Microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) cancer**
  - For the treatment of adult and pediatric patients (12 years and older for Keytruda Qlex) with unresectable or metastatic, MSI-H or dMMR solid tumors, as determined by an FDA-approved test, that have progressed following prior treatment and who have no satisfactory alternative treatment options.
- **Microsatellite instability-high or mismatch repair deficient colorectal cancer (CRC)**
  - For the treatment of adult patients with unresectable or metastatic MSI-H or dMMR CRC as determined by an FDA-approved test.
- **Gastric cancer**
  - In combination with trastuzumab, fluoropyrimidine- and platinum-containing chemotherapy for the first-line treatment of adult patients with locally advanced unresectable or metastatic HER2-positive gastric or gastroesophageal junction (GEJ) adenocarcinoma whose tumors express PD-L1 (CPS ≥ 1) as determined by an FDA-approved test.
  - In combination with fluoropyrimidine- and platinum-containing chemotherapy for the first-line treatment of adults with locally advanced unresectable or metastatic HER2-negative gastric or GEJ adenocarcinoma whose tumors express PD-L1 (CPS ≥ 1) as determined by an FDA-approved test.
- **Esophageal cancer**
  - For the treatment of adult patients with locally advanced or metastatic esophageal or GEJ (tumors with epicenter 1 to 5 centimeters above the GEJ) carcinoma that is not amenable to surgical resection or definitive chemoradiation either:
    - In combination with platinum- and fluoropyrimidine-based chemotherapy whose tumors express PD-L1 (CPS ≥ 1) as determined by an FDA-authorized test, or
    - As a single agent after one or more prior lines of systemic therapy for patients with tumors of squamous cell histology that express PD-L1 (CPS ≥ 10) as determined by an FDA approved test.

- **Cervical cancer**
  - In combination with chemoradiotherapy (CRT) for the treatment of adult patients with locally advanced cervical cancer involving the lower third of the vagina, with or without extension to pelvic sidewall, or hydronephrosis/non-functioning kidney or spread to adjacent pelvic organs (FIGO 2014 Stage III-IVA).
  - In combination with chemotherapy, with or without bevacizumab, for the treatment of adult patients with persistent, recurrent, or metastatic cervical cancer whose tumors express PD-L1 (CPS ≥ 1) as determined by an FDA-approved test.
  - As a single agent for the treatment of adult patients with recurrent or metastatic cervical cancer with disease progression on or after chemotherapy whose tumors express PD-L1 (CPS ≥ 1) as determined by an FDA-approved test.
- **Hepatocellular carcinoma (HCC)**
  - For the treatment of adult patients with HCC secondary to hepatitis B who have received prior systemic therapy other than a PD-1/PD-L1-containing regimen.
- **Biliary tract cancer (BTC)**
  - In combination with gemcitabine and cisplatin for the treatment of adult patients with locally advanced unresectable or metastatic BTC.
- **Merkel cell carcinoma (MCC)**
  - For the treatment of adult and pediatric patients (12 years and older for Keytruda Qlex) with recurrent locally advanced or metastatic MCC.
- **Renal cell carcinoma (RCC)**
  - In combination with axitinib, for the first-line treatment of adult patients with advanced RCC.
  - In combination with lenvatinib, for the first-line treatment of adult patients with advanced RCC.
  - For the adjuvant treatment of adult patients with RCC at intermediate-high or high risk of recurrence following nephrectomy or following nephrectomy and resection of metastatic lesions.
  - In combination with belzutifan, for the adjuvant treatment of adult patients with RCC with a clear cell component (ccRCC) at intermediate-high or high risk of recurrence following nephrectomy, or following nephrectomy and resection of metastatic lesions.
- **Endometrial carcinoma**
  - In combination with carboplatin and paclitaxel, followed by Keytruda or Keytruda Qlex as a single agent, for the treatment of adult patients with primary advanced or recurrent endometrial carcinoma.
  - In combination with lenvatinib, for the treatment of adult patients with advanced endometrial carcinoma that is mismatch repair proficient (pMMR) or not MSI-H as determined by an FDA-approved test, who have disease progression following prior systemic therapy in any setting and are not candidates for curative surgery or radiation.
  - As a single agent for the treatment of adult patients with advanced endometrial carcinoma that is MSI-H or dMMR, as determined by an FDA-approved test, who have disease progression following prior systemic therapy in any setting and are not candidates for curative surgery or radiation.

- **Tumor mutational burden-high (TMB-H) cancer**
  - For the treatment of adult and pediatric patients (12 years and older for Keytruda Qlex) with unresectable or metastatic tumor mutational burden-high (TMB-H) [≥ 10 mutations/megabase (mut/Mb)] solid tumors, as determined by an FDA-approved test, that have progressed following prior treatment and who have no satisfactory alternative treatment options.*
  - Limitations of use: The safety and effectiveness of Keytruda or Keytruda Qlex in pediatric patients (12 years and older for Keytruda Qlex) with TMB-H central nervous system cancers have not been established.
- **Cutaneous squamous cell carcinoma (cSCC)**
  - For the treatment of adult patients with recurrent or metastatic cSCC or locally advanced cSCC that is not curable by surgery or radiation.
- **Triple-negative breast cancer (TNBC)**
  - For the treatment of adult patients with high-risk early-stage TNBC in combination with chemotherapy as neoadjuvant treatment, and then continued as a single agent as adjuvant treatment after surgery.
  - In combination with sacituzumab govitecan-hziy, for the first-line treatment of adult patients with unresectable locally advanced or metastatic TNBC whose tumor express PD-L1 (CPS ≥ 10) as determined by an FDA-authorized test.
  - In combination with chemotherapy, for the treatment of adult patients with locally recurrent unresectable or metastatic TNBC whose tumors express PD-L1 (CPS ≥ 10) as determined by an FDA approved test.
- **Ovarian cancer**
  - In combination with paclitaxel, with or without bevacizumab, for the treatment of adult patients with platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal carcinoma whose tumors express PD-L1 (CPS ≥ 1) as determined by an FDA authorized test, and who have received one or two prior systemic treatment regimens.

Keytruda is additionally indicated:

- **Classical Hodgkin lymphoma (cHL)**
  - For the treatment of adult patients with relapsed or refractory cHL.
  - For the treatment of pediatric patients with refractory cHL, or cHL that has relapsed after 2 or more lines of therapy.
- **Primary mediastinal large B-cell lymphoma (PMBCL)**
  - For the treatment of adult and pediatric patients with refractory PMBCL, or who have relapsed after 2 or more prior lines of therapy.
  - Limitations of use: Keytruda is not recommended for treatment of patients with PMBCL who require urgent cytoreductive therapy.

** This indication is approved under accelerated approval based on tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.*

Contents:

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Keytruda and Keytruda Qlex are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Melanoma (must meet all)**:**

1. Diagnosis of melanoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 12 years;
4. For Keytruda Qlex requests, member weighs > 40 kg;
5. Disease is Stage IIB, IIC, III, recurrent, unresectable, or metastatic;

6. Prescribed as one of the following (a, b, or c):
   a. A single agent;
   b. In combination with Lenvima® or Yervoy®;
   c. In combination with Mekinist® and Tafinlar® for disease with BRAF V600 activating mutation;
7. Request meets one of the following (a, b, or c):*
   a. Keytruda: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks (for a maximum of 12 months if adjuvant treatment);
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks (for a maximum of 12 months if adjuvant treatment);
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Non-Small Cell Lung Cancer (must meet all)**:**
1. Diagnosis of NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. One of the following (a or b):
   a. Disease is resectable or resected;
   b. Disease is recurrent, advanced, or metastatic, and request meets one of the following (i, ii, iii, iv, v, or vi):
      i. Disease mutation status is positive for EGFR exon 20, KRAS G12C, NRTK1/2/3, BRAF V600E, MET exon 14 skipping, RET rearrangement, or ERBB2 (HER2);
      ii. Disease mutation status is positive for EGFR S768I, L861Q, and/or G719X, and member has received prior afatinib, osimertinib, erlotinib, gefitinib, or dacomitinib;*
      iii. Disease mutation status is positive for EGFR exon 19 deletion or L858R, and member has received prior erlotinib ± (ramucirumab or bevacizumab), afatinib, gefitinib, osimertinib, dacomitinib, or amivantamab-vmjw + lazertinib;*
      iv. Disease mutation status is positive for ROS1 rearrangement, and member has received prior crizotinib, entrectinib, or repotrecitinib;*
      v. Disease mutation status is positive for ALK rearrangement, and member has received prior crizotinib, ceritinib, alectinib, brigatinib, or lorlatinib;*
      vi. Disease mutation status is negative for actionable biomarkers (EGFR, KRAS, ALK, ROS1, BRAF, NTRK1/2/3, MET, RET, and ERBB2 [HER2]);

   **Prior authorization may be required*

5. Keytruda or Keytruda Qlex is prescribed in one of the following ways (a, b, c, d, e, or f):
   a. For PD-L1 positive disease (TPS ≥ 1%);
   b. In combination with a chemotherapy regimen *(see Appendix B)*;
   c. In combination with a chemotherapy regimen *(see Appendix B)* as neoadjuvant treatment, followed by single-agent adjuvant treatment after surgery for patients with resectable (tumors ≥ 4 cm or node positive) disease;
   d. As single-agent for those who have received previous adjuvant chemotherapy or neoadjuvant chemotherapy with pembrolizumab;
   e. As single-agent continuation maintenance therapy if previously given first line as part of a chemotherapy regimen;
   f. As single-agent adjuvant treatment following resection and platinum-based chemotherapy (e.g., cisplatin, carboplatin) for adult patients with stage IB (T2a ≥ 4 cm), II, or IIIA disease;
6. Member does not have contraindications to PD-1/PD-L1 inhibitor therapy (e.g., Opdivo®, Yervoy, Tecentriq®, Imfinzi®) (*see Appendix F*);
7. Request meets one of the following (a, b, or c):*
   a. Keytruda: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum duration of one of the following (i, ii, or iii):
      i. Adjuvant therapy: 12 months;
      ii. Neoadjvuant, followed by adjuvant treatment: 12 weeks (neoadjuvant), then 39 weeks (adjuvant treatment);
      iii. All other requests: 24 months;
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of duration of one of the following (i, ii, or iii):
      i. Adjuvant therapy: 12 months;
      ii. Neoadjvuant, followed by adjuvant treatment: 12 weeks (neoadjuvant), then 39 weeks (adjuvant treatment);
      iii. All other requests: 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

C. Malignant Pleural Mesothelioma (must meet all)**:**
1. Diagnosis of MPM;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Keytruda or Keytruda Qlex is prescribed in combination with pemetrexed and platinum-containing chemotherapy;

5. Request meets one of the following (a, b, or c):*
   a. Keytruda: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of 24 months;
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

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D. Head and Neck Squamous Cell Carcinoma (must meet all)**:**
1. Diagnosis of HNSCC *(locations include paranasal sinuses, larynx, pharynx, lip, oral cavity, salivary glands; may be occult primary – i.e., primary source unknown)*;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is resectable, locally advanced, unresectable, recurrent/persistent, or metastatic;
5. For unresectable, recurrent/persistent, or metastatic disease, prescribed in one of the following ways (a, b, c, or d):
   a. Keytruda or Keytruda Qlex: In combination with platinum-containing chemotherapy and either FU, docetaxel, or gemcitabine;
   b. Keytruda: In combination with Erbitux® as first-line therapy or subsequent-line therapy (*off-label)*;
   c. Keytruda or Keytruda Qlex: As a first-line single agent and the tumor expresses PD-L1 with a CPS of ≥ 1;
   d. Keytruda or Keytruda Qlex: As a single agent for disease that has progressed on or after platinum-containing chemotherapy (e.g., cisplatin, carboplatin);
6. For resectable locally advanced disease, all of the following (a, b, and c):
   a. Tumor expresses PD-L1 with a CPS of ≥ 1;
   b. Prescribed initially for neoadjuvant therapy as a single agent;
   c. Then continued as adjuvant therapy in combination with RT with or without cisplatin, then as a single agent;
7. For nasopharyngeal carcinoma, one of the following (a or b):*

   **For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395.*

   a. Failure of Loqtorzi® at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
   b. Request is for treatment associated with cancer for a state with regulations against step therapy in certain oncology settings (*see Appendix G*);
8. Request meets one of the following (a, b, or c):*
   a. Keytruda: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of one of the following (i, ii, or iii):
      i. Neoadjuvant therapy: 6 weeks;
      ii. Adjuvant therapy: 1 year;

iii. All other requests: 24 months;

b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of one of the following (i, ii, or iii):
   i. Neoadjuvant therapy: 6 weeks;
   ii. Adjuvant therapy: 1 year;
   iii. All other requests: 24 months;
c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

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Approval duration:
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Commercial – 6 months or to the member's renewal date, whichever is longer

E. Classical Hodgkin Lymphoma (must meet all)**:**

1. Diagnosis of cHL;
2. Request is for Keytruda;
3. Prescribed by or in consultation with an oncologist or hematologist;
4. Age ≥ 6 months;
5. Keytruda is prescribed as single-agent therapy (*adults or pediatrics*) or in combination with GVD (gemcitabine, vinorelbine, liposomal doxorubicin), ICE (ifosfamide, carboplatin, etoposide), decitabine and vorinostat (*adults only*) in one of the following ways (a, b, c, or d):
   a. For palliative therapy;
   b. Post-allogeneic hematopoietic cell transplant or post-autologous stem cell rescue;
   c. Member is not a candidate for anthracycline;
   d. For disease that is relapsed or refractory to ≥ 1 line of systemic therapy (*see Appendix B*);
6. Request meets one of the following (a, b, or c):*
   a. Adults: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of 24 months;
   b. Pediatrics: Dose does not exceed 2 mg/kg up to 200 mg every 3 weeks for a maximum of 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
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Commercial – 6 months or to the member's renewal date, whichever is longer

F. Primary Mediastinal Large B-Cell Lymphoma (must meet all)**:**

1. Diagnosis of PMBCL;
2. Request is for Keytruda;
3. Prescribed by or in consultation with an oncologist or hematologist;
4. Age ≥ 6 months;

5. Disease is refractory to or has relapsed after ≥ 1 line of systemic therapy *(see Appendix B)*;
6. Prescribed in one of the following ways (a or b):
   a. As a single agent;
   b. For age ≥ 6 months to < 18 years only, in combination with Adcetris®;
7. Request meets one of the following (a, b, or c):*
   a. Adults: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of 24 months;
   b. Pediatrics: Dose does not exceed 2 mg/kg up to 200 mg every 3 weeks for a maximum of 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

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G. Urothelial Cancer (must meet all)**:**
1. Diagnosis of urothelial cancer;
2. Prescribed by or in consultation with an oncologist or urologist;
3. Age ≥ 18 years;
4. Keytruda or Keytruda Qlex is prescribed in one of the following ways (a, b, c, d, or e):
   a. In combination with Padcev® as first-line or second-line systemic therapy;*
      **Prior authorization may be required for Padcev*
   b. As a single agent, and member is ineligible for or has previously received platinum-containing chemotherapy (e.g., cisplatin, carboplatin) or previously received other chemotherapy;
   c. For NMIBC, as a single agent for the treatment of BCG-unresponsive, high-risk disease, and member is ineligible for or has elected not to undergo cystectomy (*see Appendix D for BCG shortage information*);
   d. As a single agent for adjuvant therapy;
   e. For MIBC, in combination with Padcev® as neoadjuvant treatment and then continued after cystectomy as adjuvant treatment;*
      **Prior authorization may be required for Padcev*
5. Request meets one of the following (a, b, or c):*
   a. Keytruda, one of the following (i or ii):
      i. For MIBC, both of the following (1 and 2):
         1) Neoadjuvant treatment (a or b):
            a) Cisplatin-eligible members: Dose does not exceed 200 mg every 3 weeks for a maximum of 4 doses OR 400 mg every 6 weeks for a maximum of 2 doses;
            b) Cisplatin-ineligible members: Dose does not exceed 200 mg every 3 weeks for a maximum of 3 doses;

2) Adjuvant treatment: Dose does not exceed 200 mg every 3 weeks (for a maximum of 14 doses for cisplatin-ineligible or 13 doses for cisplatin-eligible members) OR 400 mg every 6 weeks for a maximum of 7 doses;

ii. All other indications: Dose does not exceed 200 mg every 3 weeks OR 400 mg every 6 weeks for a maximum of 24 months;

b. Keytruda Qlex, one of the following (i or ii):
   i. For MIBC, both of the following (1 and 2):
      1) Neoadjuvant treatment (a or b):
         a) Cisplatin-eligible members: Dose does not exceed 395 mg/4,800 units every 3 weeks for a maximum of 4 doses OR 790 mg/9,600 units every 6 weeks for maximum of 2 doses;
         b) Cisplatin-ineligible members: Dose does not exceed 395 mg/4,800 units every 3 weeks for a maximum of 3 doses;
      2) Adjuvant treatment: Dose does not exceed 395 mg/4,800 units every 3 weeks (for a maximum of 14 doses for cisplatin ineligible or 13 doses for cisplatin eligible members) OR 790 mg/9,600 units every 6 weeks for maximum of 7 doses;
   ii. All other indications: Dose does not exceed 395 mg/4,800 units every 3 weeks OR 790 mg/9,600 units every 6 weeks for a maximum of 24 months;
c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

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H. Microsatellite Instability-High/Mismatch Repair Deficient Cancer (must meet all)**:**
1. Diagnosis of a solid tumor classified as MSI-H or dMMR (indicative of MMR gene mutation or loss of expression) *(see Appendix E for examples of MSI-H solid tumors)*;
2. Prescribed by or in consultation with an oncologist;
3. Member meets one of the following (a or b):
   a. Keytruda: Age ≥ 6 months;
   b. Keytruda Qlex, both of the following (i and ii):
      i. Age ≥ 12 years;
      ii. Weight > 40 kg;
4. For age ≥ 6 months to < 18 years, request is not for first-line therapy;
5. Keytruda or Keytruda Qlex is prescribed in one of the following ways (a, b, c, or d):
   a. As first-line or subsequent therapy for ampullary adenocarcinoma, CRC, gallbladder cancer, gastric cancer, GEJ cancer, intrahepatic/extrahepatic cholangiocarcinoma, non-nasopharyngeal head, and neck cancer, occult primary tumor, pancreatic adenocarcinoma, or small bowel adenocarcinoma;
   b. As subsequent therapy for other solid tumors;
   c. As neoadjuvant or perioperative therapy for gallbladder cancer, gastric cancer, or GEJ adenocarcinoma, or small bowel adenocarcinoma;
   d. For any line of therapy for CRC or appendiceal neoplasms and cancers;

6. Prescribed in one of the following ways (a or b):
   a. As a single agent;
   b. For gastric or GEJ cancers: as a single agent or in combination with platinum- and fluoropyrimidine-based chemotherapy;
7. Request meets one of the following (a, b, or c):*
   a. Keytruda, one of the following (i or ii):
      i. Adults: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of 24 months;
      ii. Pediatrics: Dose does not exceed 2 mg/kg up to 200 mg every 3 weeks for a maximum of 24 months;
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

I. Gastric Cancer, Esophageal Cancer, or Gastroesophageal Junction Cancer (must meet all)**:**
1. Diagnosis of gastric cancer, esophageal cancer, or GEJ cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. One of the following (a or b):
   a. Disease is unresectable, locally advanced, recurrent, or metastatic;
   b. Member is planned for esophagectomy;
5. Member meets one of the following (a, b, or c):
   a. Keytruda or Keytruda Qlex is prescribed in combination with trastuzumab, fluoropyrimidine- and platinum-containing chemotherapy, and both (i and ii):
      i. HER2-positive gastric or GEJ adenocarcinoma;
      ii. Tumor expresses PD-L1 (CPS ≥ 1);
   b. Both of the following (i and ii):
      i. Keytruda or Keytruda Qlex is prescribed in combination with platinum- and fluoropyrimidine-based chemotherapy, and both (1 and 2):
         1) One of the following (a or b):
            a) HER2-negative gastric or GEJ adenocarcinoma;
            b) Esophageal carcinoma or GEJ squamous cell carcinoma;
         2) Tumor expresses PD-L1 (CPS ≥ 1);
      ii. One of the following (1 or 2):*

      **For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*

         1) Failure of Tevimbra® at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
         2) Request is for treatment associated with cancer for a state with regulations against step therapy in certain oncology settings (*see Appendix G*);

c. Keytruda or Keytruda Qlex is prescribed as a single agent after one or more prior lines of systemic therapy for members with tumors of squamous cell GEJ that express PD-L1 (CPS ≥ 10) *(see Appendix B)*;

6. Request meets one of the following (a, b, or c):*
   a. Keytruda: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of 24 months;
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

J. Cervical Cancer (must meet all)**:**
1. Diagnosis of cervical cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed in one of the following ways (a, b, c, or d):
   a. As a single agent, and all of the following (i, ii, and iii):
      i. Tumor expresses PD-L1 (CPS ≥ 1);
      ii. Disease is recurrent or metastatic;
      iii. Disease has progressed on or after ≥ 1 line of systemic therapy *(see Appendix B)*;
   b. In combination with chemotherapy (e.g., paclitaxel/cisplatin, paclitaxel/carboplatin) with or without bevacizumab, and both (i and ii):
      i. Tumor expresses PD-L1 (CPS ≥ 1);
      ii. Disease is persistent, recurrent, or metastatic;
   c. In combination with Tivdak®, and all of the following (i, ii, and iii):
      i. Tumor expresses PD-L1 (CPS ≥ 1) and has not received prior immune-oncology therapy;
      ii. Disease is recurrent or metastatic;
      iii. Disease has progressed on or after ≥ 1 line of systemic therapy *(see Appendix B)*;
   d. In combination with CRT, and (i):
      i. Disease is FIGO 2014 Stage III-IVA or FIGO 2018 stage III-IVA (*see Appendix F*);
5. Request meets one of the following (a, b, or c):*
   a. Keytruda: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of 24 months;
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

K. Hepatocellular Carcinoma (must meet all):
1. Diagnosis of HCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. One of the following (a or b):
   a. Prescribed as subsequent-line systemic therapy and (i):
      i. Member has not previously been treated with immune checkpoint inhibitor therapy (PD-L1/PD-1, e.g., Tecentriq, Opdivo);
      **Prior authorization may be required for Nexavar, Lenvima and Stivarga*
   b. Prescribed as first line treatment;
5. Prescribed as a single agent;
6. Request meets one of the following (a, b, or c):*
   a. Keytruda: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of 24 months;
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

L. Biliary Tract Cancer (must meet all):
1. Diagnosis of BTC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. One of the following (a or b):
   a. Disease is locally advanced unresectable or resected gross residual (R2) disease, or metastatic;
   b. Disease is resectable locoregionally advanced and prescribed as neoadjuvant therapy for gallbladder cancer;
5. Failure of Imfinzi®, at up to maximally indicated doses, unless contraindicated, clinically significant adverse effects are experienced, or request is for treatment associated with cancer for a State with regulations against step therapy in certain oncology settings *(see Appendix G)*;*
   **For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
6. Prescribed in combination with gemcitabine and cisplatin;

7. Request meets one of the following (a, b, or c):*
   a. Keytruda: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of 24 months;
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

M. Merkel Cell Carcinoma (must meet all)**:**
1. Diagnosis of MCC;
2. Prescribed by or in consultation with an oncologist;
3. Member meets one of the following (a or b):
   a. Keytruda: Age ≥ 6 months;
   b. Keytruda Qlex, both of the following (i and ii):
      i. Age ≥ 12 years;
      ii. Weight > 40 kg;
4. Disease is recurrent, locally advanced, or metastatic;
5. Prescribed as a single agent;
6. Request meets one of the following (a, b, or c):*
   a. Keytruda, one of the following (i or ii):
      i. Adults: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of 24 months;
      ii. Pediatrics: Dose does not exceed 2 mg/kg up to 200 mg every 3 weeks for a maximum of 24 months;
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

N. Renal Cell Carcinoma (must meet all)**:**
1. Diagnosis of RCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed in one of the following ways (a, b, or c):
   a. Keytruda or Keytruda Qlex: In combination with Inlyta or Lenvima*, and disease is advanced (i.e., relapsed or stage IV);

      **Prior authorization may be required for Inlyta and Lenvima.*

b. Keytruda or Keytruda Qlex: As adjuvant treatment, and all of the following (i, ii, and iii):
   i. As single agent or in combination with Welireg®;
   ii. Disease is clear cell histology;
   iii. Member is at intermediate-high or high risk of recurrence following nephrectomy, or following nephrectomy and resection of metastatic lesions;
c. Keytruda: As a single agent for relapsed or stage IV disease with non-clear cell histology (off-label);

5. Request meets one of the following (a, b, or c):*
   a. Keytruda: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of 12 months for adjuvant therapy or 24 months for all other uses;
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of 12 months for adjuvant therapy or 24 months for all other uses;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

O. Endometrial Carcinoma (must meet all)**:**
1. Diagnosis of endometrial carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed in one of the following (a or b):
   a. In combination with Lenvima* and both of the following (i and ii):
      **Prior authorization may be required for Lenvima*
      i. Disease is pMMR or not MSI-H;
         **See criteria set I.G. for MSI-H/dMMR endometrial carcinoma*
      ii. Progressed following prior systemic therapy (e.g., carboplatin/paclitaxel);
   b. In combination with carboplatin and paclitaxel and continued as a single agent for maintenance therapy for advanced, recurrent, or Stage III-IV disease;
5. Request meets one of the following (a, b, or c):*
   a. Keytruda: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of 24 months;
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

P. Tumor Mutational Burden-High Cancer (must meet all)**:**
1. Diagnosis of a solid tumor classified as TMB-H (i.e., ≥ 10 mutations/megabase [mut/Mb]) (*see Appendix E for examples of TMB-H solid tumors*);
2. Prescribed by or in consultation with an oncologist;
3. Member meets one of the following (a or b):
   a. Keytruda: Age ≥ 6 months;
   b. Keytruda Qlex, both of the following (i and ii):
      i. Age ≥ 12 years;
      ii. Weight > 40 kg;
4. Disease is unresectable, recurrent, or metastatic;
5. One of the following (a, b, or c):
   a. Disease has progressed following prior treatment;
   b. Prescribed as a first-line therapy for ampullary adenocarcinoma, pancreatic adenocarcinoma, or non-NPC;
   c. For appendiceal neoplasms and cancers or CRC, any line of therapy;
6. Prescribed as a single agent;
7. Request meets one of the following (a, b, or c):*
   a. Keytruda, one of the following (i or ii):
      i. Adults: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of 24 months;
      ii. Pediatrics: Dose does not exceed 2 mg/kg up to 200 mg every 3 weeks for a maximum of 24 months;
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

Q. Cutaneous Squamous Cell Carcinoma (must meet all)**:**
1. Diagnosis of cSCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Member is not a candidate for curative surgery or radiation;
5. Prescribed as a single agent;
6. Request meets one of the following (a, b, or c):*
   a. Keytruda: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of 24 months;
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

R. Triple Negative Breast Cancer (must meet all)**:**
1. Diagnosis of TNBC (i.e., estrogen receptor/progesterone receptor [ER/PR] negative and human epidermal growth factor receptor 2 [HER2]-negative);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. One of the following (a, b, or c):
   a. Disease is high-risk early-stage (*see Appendix F*), and (i):
      i. Prescribed in combination with chemotherapy (e.g., carboplatin, paclitaxel, doxorubicin, cyclophosphamide) as neoadjuvant treatment, and then continued as a single agent as adjuvant treatment after surgery;
   b. Disease is locally advanced or recurrent unresectable or metastatic, and both of the following (i and ii):
      i. Tumor expresses PD-L1 (CPS ≥ 10);
      ii. Prescribed in combination with Trodelvy® or chemotherapy (e.g., paclitaxel, paclitaxel protein-bound, gemcitabine and carboplatin);
   c. Prescribed as preoperative systemic therapy in combination with carboplatin and docetaxel;
5. Request meets one of the following (a, b, or c):*
   a. Keytruda: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of (i or ii):
      i. High-risk, early-stage TNBC: 24 weeks as neoadjuvant therapy and 27 weeks as adjuvant therapy;
      ii. Locally recurrent unresectable or metastatic TNBC: 24 months;
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of (i or ii):
      i. High-risk, early-stage TNBC: 24 weeks as neoadjuvant therapy and 27 weeks as adjuvant therapy;
      ii. Locally recurrent unresectable or metastatic TNBC: 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

S. Ovarian Cancer (must meet all):
1. Diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is platinum-resistant (i.e., cancer returns less than 6 months after finishing platinum-based chemotherapy);

5. Member has received 1 or 2 prior lines of systemic therapy;
6. Prescribed in one of the following ways (a or b):
   a. In combination with paclitaxel, and tumor expresses PD-L1 (CPS ≥ 1);
   b. In combination with cyclophosphamide and bevacizumab (*off-label);*
7. Request meets one of the following (a, b, or c):*
   a. Keytruda: Dose does not exceed 200 mg every 3 weeks or 400 mg every 6 weeks for a maximum of 24 months;
   b. Keytruda Qlex: Dose does not exceed 395 mg/4,800 units every 3 weeks or 790 mg/9,600 units every 6 weeks for a maximum of 24 months;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

T. Pediatric Glioma (off-label) (must meet all):
1. Diagnosis of hypermutant tumor diffuse high-grade glioma;
2. Request is for Keytruda;
3. Prescribed by or in consultation with an oncologist;
4. Age ≥ 6 months and < 18 years;
5. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).*

   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

U. NCCN Recommended Uses (off-label) (must meet all)**:**
1. Diagnosis of one of the following (a, b, c, d, e, f, or g):
   a. Recurrent conventional chordoma (including chondroid) or dedifferentiated chondrosarcoma as a single agent;
   b. Chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) with histologic (Richter) transformation to diffuse B-cell lymphoma and both of the following (i and ii):
      i. Request is for Keytruda;
      ii. As a single agent or in combination with ibrutinib*

      **Prior authorization may be required for ibrutinib*
   c. Metastatic, recurrent, or progressive anal carcinoma, and one of the following (i or ii):
      i. Prescribed in combination with paclitaxel and carboplatin;
      ii. Prescribed as a single agent and member has not previously received Keytruda or Opdivo;

d. Soft tissue sarcoma subtypes: Myxofibrosarcoma, undifferentiated pleomorphic sarcoma (UPS), dedifferentiated liposarcoma, cutaneous angiosarcoma, and undifferentiated sarcomas; one of the following (i, ii, or iii):
   i. As single-agent subsequent therapy;
   ii. As single-agent for cutaneous angiosarcoma or dedifferentiated liposarcoma;
   iii. As neoadjuvant or adjuvant therapy for UPS related sarcomas;
e. Advanced, recurrent, metastatic vulvar cancer, prescribed as second-line or subsequent therapy as one of the following (i or ii):
   i. In combination with paclitaxel and cisplatin or carboplatin;
   ii. As single-agent with PD-L1 positive (CPS ≥ 1) disease;
f. Prescribed as first-line or subsequent therapy:
   i. Central nervous system (CNS) cancer (e.g., brain metastases);
   ii. Stage IA - III mycosis fungoides;
   iii. Stage IV Sezary syndrome;
   iv. Malignant histiocytic neoplasms (MHN);
   v. Unresectable or metastatic adrenocortical carcinoma;
   vi. Alveolar soft part sarcoma;
   vii. Thymic carcinoma, and prescribed as a single agent;
   viii. Thyroid carcinoma (papillary, follicular, oncolytic);
   ix. Metastatic anaplastic carcinoma;
   x. Unresectable, metastatic or recurrent PD-L1-positive (CPS ≥ 1) vaginal cancer;
   xi. Peritoneal mesothelioma, and prescribed in combination with platinum-containing chemotherapy and pemetrexed;
   xii. Recurrent or metastatic penile cancer, and prescribed in combination with fluorouracil and platinum-containing chemotherapy;
g. Prescribed as single-agent subsequent therapy:
   i. Gestational trophoblastic neoplasia;
   ii. Extranodal NK/T-cell lymphoma, request is for Keytruda;
   iii. Relapsed or refractory cutaneous anaplastic large cell lymphoma, request is for Keytruda;
   iv. Relapsed or primary progressive small cell lung cancer, request is for Keytruda;
   v. Kaposi sarcoma, request is for Keytruda;

2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).*
   **Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

V. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Keytruda or Keytruda Qlex for a covered indication and has received this medication for at least 30 days;
2. For cHL, PMBCL, pediatric glioma, and other off-label indications (see Section I.T), request is for Keytruda;
3. Member is responding positively to therapy;
4. Member has NOT received the maximum duration of therapy as described below (a, b, c, d, e, or f):
   a. Adjuvant melanoma or RCC treatment: up to 12 months;
   b. For high-risk, early stage TNBC: up to 24 weeks if neoadjuvant treatment, followed by 27 weeks as adjuvant treatment;
   c. NSCLC, one of the following (i, ii, or iii):
      i. Adjuvant treatment: 12 months;
      ii. Neoadjuvant, followed by adjuvant treatment: 12 weeks (neoadjuvant), then 39 weeks (adjuvant treatment);
      iii. All other requests: 24 months;
   d. HNSCC, one of the following (i, iii, or iii):
      i. Neoadjuvant treatment: 6 weeks;
      ii. Adjuvant treatment: 1 year;
      iii. All other requests: 24 months;
   e. MIBC, one of the following (i or ii):
      i. Neoadjuvant treatment: one of the following (1 or 2):
         1) Cisplatin-ineligible: 3 doses for every 3 week regimen;
         2) Cisplatin eligible: 4 doses for every 3 week regimen or 2 doses for every 6 week regimen;

ii. Adjuvant treatment: one of the following (1 or 2):
1) Cisplatin-ineligible: 14 doses for every 3 week regimen or 7 doses for every 6 week regimen;
2) Cisplatin-eligible: 13 doses every 3 week regimen or 7 doses for every 6 week regimen;

f. All other FDA-approved indications: up to 24 months;

5. If request is for a dose increase, request meets one of the following (a, b, or c):*
a. Keytruda (i or ii):
i. Adults (1 or 2):
1) New dose does not exceed 200 mg every 3 weeks;
2) New dose does not exceed 400 mg every 6 weeks;
ii. Pediatrics: New dose does not exceed 2 mg/kg up to 200 mg every 3 weeks;
b. Keytruda Qlex (i or ii):
i. New dose does not exceed 395 mg/4,800 units every 3 weeks;
ii. New dose does not exceed 790 mg/9,600 units every 6 weeks;
c. New dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy –

CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid or evidence of coverage documents;

B. Pediatric patients with MSI-H or TMB-H central nervous cancers.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ALK: anaplastic lymphoma kinase
ASPS: alveolar soft part sarcoma
BCG: Bacillus Calmette-Guerin
BTC: biliary tract cancer
ccRCC: RCC with a clear cell component
cHL: classical Hodgkin lymphoma
CIS: carcinoma in situ
CLL: chronic lymphocytic leukemia
CNS: central nervous system
CPS: combined positive score
CRC: colorectal cancer
CRT: chemoradiotherapy
cSCC: cutaneous squamous cell carcinoma
dMMR: mismatch repair deficient
EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
GEJ: gastroesophageal junction
HCC: hepatocellular carcinoma
HER2: human epidermal growth factor receptor 2
HNSCC: head and neck squamous cell carcinoma
MCC: Merkel cell carcinoma
MHN: malignant histiocytic neoplasms
MPM: malignant pleural mesothelioma
MSI-H: microsatellite instability-high
mut/Mb: mutations/megabase
NCCN: National Comprehensive Cancer Network
NMIBC: non-muscle invasive bladder cancer
NSCLC: non-small cell lung cancer
PD-1: programmed death protein 1
PD-L1: programmed death-ligand 1
PMBCL: primary mediastinal large B-cell lymphoma
pMMR: mismatch repair proficient
RCC: renal cell carcinoma
ROS1: ROS proto-oncogene 1
SLL: small lymphocytic lymphoma
TMB-H: tumor mutational burden-high
TNBC: triple-negative breast cancer
TPS: tumor proportion score

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Section I.B: Non-Small Cell Lung Cancer Examples of drugs used in combination with Keytruda: • Carboplatin, cisplatin, pemetrexed, paclitaxel Examples of targeted therapies: • EGFR S768I, L861Q, and/or G719X targeted therapies: afatinib, osimertinib, erlotinib, gefitinib, dacomitinib • EGFR exon 19 deletion or L858R targeted therapies: erlotinib ± (ramucirumab or bevacizumab), afatinib,	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
gefitinib, osimertinib, dacomitinib, or amivantamab-vmjw + lazertinib • ROS1 targeted therapies: crizotinib, entrectinib, repotrecitnib • ALK rearrangement targeted therapies: crizotinib, ceritinib, alectinib, brigatinib, lorlatinib		
Section I.D: Head and Neck Squamous Cell Carcinoma Nasopharyngeal carcinoma (NPC) • Loqtorzi (toripalimab-tpzi)	First-line treatment for NPC: 240 mg IV every three weeks up to 24 months in combination with cisplatin and gemcitabine Previously treated, unresectable or metastatic NPC 3 mg/kg IV every two weeks	First-line treatment for NPC: 240 mg/3 weeks Previously treated, unresectable or metastatic NPC 3 mg/kg every two weeks
Section I.E: Classical Hodgkin Lymphoma Adults: Examples of chemotherapy regimens: • ABVD (doxorubicin, bleomycin, vinblastine, dacarbazine) • Stanford V (doxorubicin, vinblastine, mechlorethamine, etoposide, vincristine, bleomycin, prednisone) • BEACOPP (bleomycin, etoposide, doxorubicin, cyclophosphamide, vincristine, probarbazine, prednisone) • Brentuximab vedotin + AVD (doxorubicin, vinblastine, dacarbazine) Pediatrics: Examples of chemotherapy regimens • AVPC (doxorubicin, vincristine, prednisone, cyclophosphamide) • ABVE-PC (doxorubicin, bleomycin, vincristine, etoposide, prednisone, cyclophosphamide) • Brentuximab vedotin + bendamustine	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
• ICE (ifosfamide, carboplatin, etoposide)		
Section I.F: Primary Mediastinal Large B-Cell Lymphoma Examples of drugs used in single- or multi-drug chemotherapy regimens: • Bendamustine, brentuximab vedotin, carboplatin, cisplatin, cyclophosphamide, cytarabine, dexamethasone, doxorubicin, etoposide, gemcitabine, ibrutinib, ifosfamide, lenalidomide, mesna, mitoxantrone, methylprednisolone, oxaliplatin, prednisone, procarbazine, rituximab, vincristine, vinorelbine* **Various combinations of the listed drugs are components of the following chemotherapy regimens: CEOP, CEPP, DHAP, DHAX, EPOCH-R, ESHAP, GDP, GemOx, ICE, MINE, RCDOP, RCEOP, RCEPP, RCHOP, RGCVP*	Varies	Varies
Section I.G: Urothelial Carcinoma TICE® BCG (attenuated, live culture preparation of the Bacillus of Calmette and Guerin strain of *Mycobacterium bovis* for ***intravesical*** use). References for BCG dosing, dosing in the setting of a BCG shortage, and BCG shortage status are listed below and at Appendix D: 1. TICE BCG package insert: https://www.fda.gov/vaccines-blood-biologics/vaccines/tice-bcg 2. American Urological Association: Important message about the BCG shortage: https://www.auanet.org/about-us/bcg-shortage-info 3. Centers for Disease Control's current shortages page: https://www.fda.gov/vaccines-blood-biologics/safety-availability-biologics/cber-regulated-products-current-shortages	Varies	Varies
Section I.I: Gastric, EGJ, and Esophageal Cancer Examples of drugs used in single- or multi-drug chemotherapy regimens:* • Cisplatin, carboplatin, oxaliplatin, paclitaxel, docetaxel, fluorouracil, capecitabine, irinotecan, leucovorin, epirubicin, ramucirumab (for EGJ adenocarcinoma or esophageal adenocarcinoma only) **Trastuzumab may be added to some chemotherapy regimens for HER2 overexpression.*	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Section I.I: Gastric, EGJ, and Esophageal Cancer Tevimbra (tislelizumab-jsgr)	200 mg IV on Day 1 of every 3-week cycle	See regimen
Section I.J: Cervical Cancer Examples of drugs used in single- or multi-drug chemotherapy regimens: • Cisplatin, carboplatin, paclitaxel, docetaxel, bevacizumab, topotecan, fluorouracil, gemcitabine, ifosfamide, irinotecan, topotecan, mitomycin, pemetrexed, vinorelbine Examples of CRT regimens: • Cisplatin plus external beam radiation therapy (EBRT), followed by brachytherapy (BT)	Varies	Varies
Section I.K: Hepatocellular Carcinoma Nexavar (sorafenib)	400 mg PO BID	800 mg/day
Section I.K: Hepatocellular Carcinoma Lenvima (lenvatinib)	12 mg PO QD (patients ≥ 60 kg) or 8 mg PO QD (patients < 60 kg)	12 mg/day
Section I.K: Hepatocellular Carcinoma Stivarga (regorafenib)	160 mg PO QD for the first 21 days of each 28-day cycle	160 mg/day on days 1 to 21, every 28 days
Section I.K: Hepatocellular Carcinoma Cabometyx (cabozantinib)	60 mg PO QD	60 mg/day
Section I.L: Biliary Tract Cancer Imfinzi (durvalumab)	≥ 30 kg: 1,500 mg IV every 3 weeks in combination with chemotherapy, then 1,500 mg every 4 weeks < 30 kg: 20 mg/kg IV every 3 weeks in combination with chemotherapy, then 20 mg/kg every 4 weeks	See regimen
Section I.O: Endometrial Carcinoma Examples of chemotherapy regimens:*	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
• Carboplatin/paclitaxel, cisplatin/docetaxel, cisplatin/doxorubicin, carboplatin/paclitaxel/bevacizumab, carboplatin/paclitaxel/trastuzumab, ifosfamide/paclitaxel, cisplatin/ifosfamide, everolimus/letrozole, temsirolimus, Keytruda (pembrolizumab) _____ **Individual drugs used in combination regimens may also be used as monotherapy (refer to NCCN Uterine Neoplasms Guidelines)*		
Section I.S: Ovarian Cancer Examples of chemotherapy regimens: • Carboplatin/paclitaxel ± bevacizumab, paclitaxel/cisplatin, carboplatin/doxorubicin, docetaxel/carboplatin ± bevacizumab, fluorouracil/oxaliplatin/leucovorin ± bevacizumab, capecitabine/oxaliplatin ± bevacizumab, cyclophosphamide/bevacizumab, docetaxel, etoposide, gemcitabine, doxorubicin ± bevacizumab, topotecan, capecitabine, pemetrexed, vinorelbine, ifosfamide, irinotecan, melphalan	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: Keytruda Therapy for Urinary Bladder CIS in the Event of a BCG Shortage
- National Comprehensive Cancer Network (NCCN) information and recommendations:
  - Standard urinary bladder CIS therapy includes lesion resection followed by intravesical BCG.
  - The NCCN advises that in the event of a BCG shortage, BCG should be prioritized for induction of high-risk patients (e.g., high-grade T1 and CIS) and that, if feasible, the dose of BCG may be split (1/3 or 1/2 dose) so that multiple patients may be treated with a single vial in the event of a shortage.
  - If BCG is unavailable, the NCCN recommends the following alternatives:
    - Intravesical chemotherapy agents as first-line and subsequent therapy (e.g., gemcitabine, mitomycin, epirubicin, valrubicin, docetaxel, sequential gemcitabine/docetaxel, gemcitabine/mitomycin);
    - Initial radical cystectomy if patient is a surgical candidate.
  - The NCCN recommendations do not include off-label use of Keytruda as first-line or subsequent therapy in the absence of BCG failure.

- In its BCG June 2020 supply update sent to providers, Merck confirms a path forward to expand BCG manufacturing but cautions that the expansion could take years to fully realize. Merck directs providers to their wholesalers and distributors for supply questions and also provides its National Service Center number (800-672-6372) for additional information.

1. *National Comprehensive Cancer Network Guidelines. Bladder Cancer Version 1.2025. Available at https://www.nccn.org/professionals/physician_gls/pdf/bladder.pdf. Accessed May 29, 2025.*
2. *Merck Supply Update: TICE BCG LIVE (for intravesical use). June 2020.*

Appendix E: Examples of Solid Tumors per Pivotal Trials by "N" (descending)

MSI-H Solid Tumors	TMB-H Solid Tumors
CRC	Small cell lung cancer
Endometrial cancer	Cervical cancer
Biliary cancer	Endometrial cancer
Gastric or GE junction cancer	Anal cancer
Pancreatic cancer	Vulvar cancer
Small intestinal cancer	Neuroendocrine cancer
Breast cancer	Salivary cancer
Prostate cancer	Thyroid cancer
Bladder cancer	Mesothelioma cancer
Esophageal cancer	*Additional examples – NCCN compendium*: Adrenal tumor, ampullary adenocarcinoma, appendiceal cancer/ breast cancer, ovarian / fallopian tube / primary peritoneal cancer, chondroma, chondrosarcoma, head and neck cancer, Ewing sarcoma, nasopharynx cancer, occult primary carcinoma, osteosarcoma, pancreatic cancer, prostate cancer, testicular cancer, small bowel adenocarcinoma, soft tissue sarcoma, uterine sarcoma, vaginal cancer
Sarcoma	
Thyroid cancer	
Retroperitoneal adenocarcinoma	
Small cell lung cancer	
Renal cell cancer	
Additional examples – NCCN compendium: Adrenal tumor, ampullary adenocarcinoma, cervical / vulvar / ovarian / fallopian tube / primary peritoneal cancer, chondrosarcoma, chondroma, Ewing sarcoma, head and neck cancer, hepatocellular carcinoma, neuroendocrine cancer, occult primary carcinoma, osteosarcoma, penile cancer, small bowel adenocarcinoma, soft tissue sarcoma, testicular cancer, vaginal cancer	

Appendix F: General Information

- High-risk early-stage TNBC was defined as tumor size > 1 cm but ≤ 2 cm in diameter with nodal involvement or tumor size > 2 cm in diameter regardless of nodal involvement in the pivotal KEYNOTE-522 study.
- Although Keytruda's approval for small cell lung cancer was withdrawn due to lack improvement in overall survival in phase 3 randomized trial data, the NCCN continues to

recommend this use, stating that "pembrolizumab [is] just as effective as, and sometimes better than, the other subsequent therapy options."

- Per NCCN, contraindications for treatment with PD-1/PD-L1 inhibitors may include active or previously documented autoimmune disease and/or current use of immunosuppressive agents, or presence of an oncogene (i.e., EGFR exon 19 deletion or exon 21 L858R, ALK rearrangements), which has been shown to be associated with less benefit.
- FIGO 2014 and 2018 stages:
  - FIGO 2014 Stage III-IVA locally advanced cervical cancer is defined as tumor involvement of the lower third of the vagina, with or without extension onto pelvic sidewall, or hydronephrosis/non-functioning kidney, or spread to adjacent pelvic organs.
  - FIGO 2018 contains a new stage category (IIIC) with the presence of micrometastasis. FIGO 2018 IIIC is defined as involvement of pelvic and/or para-aortic lymph nodes (including micrometastases), irrespective of tumor size and extent
- Cisplatin ineligibility is defined as meeting at least one of the following criteria: creatinine clearance of less than 60 ml/min, ECOG PS 2 or higher, Grade 2 or higher hearing loss, NYHA Class III or higher heart failure, or Grade 2 or higher peripheral neuropathy

Appendix G: States with Regulations against Redirections in Cancer

State	Step Therapy Prohibited?	Notes
FL	Yes	For stage 4 metastatic cancer and associated conditions
GA	Yes	For stage 4 metastatic cancer. Redirection does not refer to review of medical necessity or clinical appropriateness
IA	Yes	For standard of care stage 4 cancer drug use, supported by peer-reviewed, evidence-based literature, and approved by FDA
IN	Yes	For advanced, metastatic cancer and associated conditions
LA	Yes≠	For stage 4 advanced, metastatic cancer or associated conditions. ≠Exception if clinically equivalent therapy, contains identical active ingredient(s), and proven to have same efficacy
MS	Yes	For advanced metastatic cancer and associated conditions
NV	Yes	Stage 3 and stage 4 cancer patients for a prescription drug to treat the cancer or any symptom thereof of the covered person
OH	Yes	For stage 4 metastatic cancer and associated conditions
OK	Yes	For advanced metastatic cancer and associated conditions
PA	Yes	For stage 4 advanced, metastatic cancer
TN	Yes^	For cancer and associated conditions ^ Exception if step therapy is AB-rated generic equivalent, interchangeable biological product, or biosimilar product to the equivalent brand drug
TX	Yes	For stage 4 advanced, metastatic cancer and associated conditions

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Pembrolizumab (Keytruda)	***Pediatrics***		
	cHL, PMBCL, MSI-H or dMMR cancer, MCC, TMB-H cancer	2 mg/kg IV every 3 weeks up to 24 months	200 mg every 3 weeks
	Melanoma	2 mg/kg IV every 3 weeks up to 12 months	200 mg every 3 weeks
	Adults		
	Melanoma	200 mg IV every 3 weeks OR 400 mg every 6 weeks If adjuvant therapy up to 12 months	200 mg every 3 weeks OR 400 mg every 6 weeks
	HNSCC	200 mg IV every 3 weeks OR 400 mg every 6 weeks for the following durations: up to 24 months* OR 6 weeks for neoadjuvant treatment** OR 1 year for adjuvant treatment*** **As single-agent therapy or in combination with chemotherapy* ***As single-agent therapy* ****In combination with RT with or without cisplatin, then continued as a single agent*	200 mg every 3 weeks OR 400 mg every 6 weeks
	NSCLC	200 mg IV every 3 weeks OR 400 mg every 6 weeks for the following durations: up to 24 months* OR up to 12 months for adjuvant treatment** OR 12 weeks for neoadjuvant treatment*** followed by adjuvant treatment for 39 weeks** **As single-agent therapy or in combination with chemotherapy* ***As single-agent therapy* **** In combination with chemotherapy*	200 mg every 3 weeks OR 400 mg every 6 weeks
	MPM, cHL, PMBCL, urothelial cancer, MSI-H or dMMR cancer (including endometrial	200 mg IV every 3 weeks OR 400 mg every 6 weeks up to 24 months*	200 mg every 3 weeks OR 400 mg every 6 weeks

Drug Name	Indication	Dosing Regimen	Maximum Dose
	carcinoma), gastric cancer, esophageal cancer, cervical cancer, HCC, BTC, MCC, TMB-H cancer, cSCC	**Esophageal cancer or gastric cancer: as single-agent therapy or in combination with chemotherapy* *For cervical cancer: as single-agent therapy or in combination with chemotherapy or CRT* *For urothelial cancer: as single-agent therapy or in combination with Padcev.* *For BTC, MPM: in combination with chemotherapy*	
	RCC (combination therapy)	200 mg IV every 3 weeks OR 400 mg every 6 weeks in combination with one of the following: • axitinib or lenvatinib for up to 24 months OR • belzutifan for up to 12 months	200 mg every 3 weeks OR 400 mg every 6 weeks
	RCC (monotherapy)	200 mg IV every 3 weeks OR 400 mg every 6 weeks for up to 12 months	200 mg every 3 weeks OR 400 mg every 6 weeks
	Endometrial carcinoma (combination therapy)	200 mg IV every 3 weeks OR 400 mg every 6 weeks prior to carboplatin and paclitaxel when given on the same day or in combination with lenvatinib, up to 24 months	200 mg every 3 weeks OR 400 mg every 6 weeks
	TNBC	200 mg IV every 3 weeks OR 400 mg every 6 weeks* for the following durations: • High-risk early-stage TNBC – neoadjuvant: 24 weeks • High-risk early-stage TNBC – adjuvant: 27 weeks • Unresectable locally advanced, locally recurrent unresectable, or metastatic TNBC: 24 months **In combination with chemotherapy for high-risk early-stage TNBC when used as neoadjuvant treatment and*	200 mg every 3 weeks OR 400 mg every 6 weeks

Drug Name	Indication	Dosing Regimen	Maximum Dose
		for locally recurrent unresectable or metastatic TNBC. In combination with sacituzumab govitecan-hziy for unresectable locally advanced or metastatic TNBC.	
	MIBC	<u>Patients who are cisplatin-eligible:</u> • Neoadjuvant: 200 mg every 3 weeks for 4 doses OR 400 mg every 6 weeks for 2 doses in combination with enfortumab vedotin • Adjuvant: 200 mg every 3 weeks for 13 doses OR 400 mg every 6 weeks for 7 doses in combination with enfortumab vedotin <u>Patients who are cisplatin-ineligible:</u> • Neoadjuvant: 200 mg every 3 weeks for 3 doses in combination with enfortumab vedotin • Adjuvant: 200 mg every 3 weeks for 14 doses OR 400 mg every 6 weeks for 7 doses in combination with enfortumab vedotin	200 mg every 3 weeks OR 400 mg every 6 weeks
	Ovarian cancer	200 mg IV every 3 weeks OR 400 mg every 6 weeks prior to paclitaxel with or without bevacizumab when given on the same day, up to 24 months	200 mg every 3 weeks OR 400 mg every 6 weeks
Pembrolizumab/ berahyaluronidase alfa-pmph (Keytruda Qlex)	***Pediatrics***		
	MSI-H or dMMR cancer, MCC, TMB-H cancer	395 mg/4,800 units SC every 3 weeks OR 790 mg/9,600 units SC every 6 weeks up to 24 months	395 mg/4,800 units every 3 weeks OR 790 mg/9,600 units every 6 weeks
	Melanoma	395 mg/4,800 units SC every 3 weeks OR 790 mg/9,600 units	395 mg/4,800 units every 3 weeks OR 790

Drug Name	Indication	Dosing Regimen	Maximum Dose
		SC every 6 weeks up to 12 months	mg/9,600 units every 6 weeks
	Adults		
	Melanoma	395 mg/4,800 units SC every 3 weeks OR 790 mg/9,600 units SC every 6 weeks If adjuvant therapy up to 12 months	395 mg/4,800 units every 3 weeks OR 790 mg/9,600 units every 6 weeks
	HNSCC	395 mg/4,800 units SC every 3 weeks OR 790 mg/9,600 units SC every 6 weeks for the following durations: up to 24 months* OR 6 weeks for neoadjuvant treatment** OR 1 year for adjuvant treatment*** **As single-agent therapy or in combination with chemotherapy* ***As single-agent therapy* ****In combination with RT with or without cisplatin, then continued as a single agent*	395 mg/4,800 units every 3 weeks OR 790 mg/9,600 units every 6 weeks
	NSCLC	395 mg/4,800 units SC every 3 weeks OR 790 mg/9,600 units SC every 6 weeks for the following durations: up to 24 months* OR up to 12 months for adjuvant treatment** OR 12 weeks for neoadjuvant treatment*** followed by adjuvant treatment for 39 weeks** **As single-agent therapy or in combination with chemotherapy* ***As single-agent therapy* **** In combination with chemotherapy*	395 mg/4,800 units every 3 weeks OR 790 mg/9,600 units every 6 weeks
	MPM, urothelial cancer, MSI-H or dMMR cancer (including endometrial carcinoma), gastric cancer, esophageal cancer, cervical cancer, HCC, BTC,	395 mg/4,800 units SC every 3 weeks OR 790 mg/9,600 units SC every 6 weeks up to 24 months* **Esophageal cancer or gastric cancer: as single-agent therapy or in combination with chemotherapy* *For cervical cancer: as single-agent therapy or in combination with chemotherapy or CRT*	395 mg/4,800 units every 3 weeks OR 790 mg/9,600 units every 6 weeks

Drug Name	Indication	Dosing Regimen	Maximum Dose
	MCC, TMB-H cancer, cSCC	*For urothelial cancer: as single-agent therapy or in combination with Padcev.* *For BTC, MPM: in combination with chemotherapy*	
	RCC (combination therapy)	395 mg/4,800 units SC every 3 weeks OR 790 mg/9,600 units SC every 6 weeks in combination with one of the following: • axitinib or lenvatinib for up to 24 months OR • belzutifan for up to 12 months	395 mg/4,800 units every 3 weeks OR 790 mg/9,600 units every 6 weeks
	RCC (monotherapy)	395 mg/4,800 units SC every 3 weeks OR 790 mg/9,600 units SC every 6 weeks for up to 12 months	395 mg/4,800 units every 3 weeks OR 790 mg/9,600 units every 6 weeks
	Endometrial carcinoma (combination therapy)	395 mg/4,800 units SC every 3 weeks OR 790 mg/9,600 units SC every 6 weeks prior to carboplatin and paclitaxel when given on the same day or in combination with lenvatinib, up to 24 months	395 mg/4,800 units every 3 weeks OR 790 mg/9,600 units every 6 weeks
	TNBC	395 mg/4,800 units SC every 3 weeks OR 790 mg/9,600 units SC every 6 weeks* for the following durations: • High-risk early-stage TNBC – neoadjuvant: 24 weeks • High-risk early-stage TNBC – adjuvant: 27 weeks • Unresectable locally advanced, locally recurrent unresectable metastatic TNBC: 24 months **In combination with chemotherapy for high-risk early-stage TNBC when used as neoadjuvant treatment and for locally recurrent unresectable or*	395 mg/4,800 units every 3 weeks OR 790 mg/9,600 units every 6 weeks

Drug Name	Indication	Dosing Regimen	Maximum Dose
		metastatic TNBC. In combination with sacituzumab govitecan-hziy for unresectable locally advanced or metastatic TNBC.	
	MIBC	Patients who are cisplatin-eligible: • Neoadjuvant: 395 mg/4,800 units every 3 weeks for 4 doses OR 790 mg/9,600 units every 6 weeks for 2 doses in combination with enfortumab vedotin • Adjuvant: 395 mg/4,800 units every 3 weeks for 13 doses OR 790 mg/9,600 units every 6 weeks for 7 doses in combination with enfortumab vedotin Patients who are cisplatin-ineligible: • Neoadjuvant: 395 mg/4,800 units every 3 weeks for 3 doses in combination with enfortumab vedotin • Adjuvant: 395 mg/4,800 units every 3 weeks for 14 doses OR 790 mg/9,600 units every 6 weeks for 7 doses in combination with enfortumab vedotin	395 mg/4,800 units every 3 weeks OR 790 mg/9,600 units every 6 weeks
	Ovarian cancer	395 mg/4,800 units SC every 3 weeks OR 790 mg/9,600 units SC every 6 weeks prior to paclitaxel with or without bevacizumab when given on the same day, up to 24 months	395 mg/4,800 units every 3 weeks OR 790 mg/9,600 units every 6 weeks

VI. Product Availability

Drug Name	Availability
Pembrolizumab (Keytruda)	Solution, single-dose vial: 100 mg/4 mL

Drug Name	Availability
Pembrolizumab/ berahyaluronidase alfa-pmph (Keytruda Qlex)	Single-dose vials: • 395 mg pembrolizumab and 4,800 units berahyaluronidase alfa per 2.4 mL • 790 mg pembrolizumab and 9,600 units berahyaluronidase alfa per 4.8 mL

VII. References

1. Keytruda Prescribing Information. Rahway, NJ: Merck and Co.; July 2026. Available at https://www.merck.com/product/usa/pi_circulars/k/keytruda/keytruda_pi.pdf. Accessed July 14, 2026.
2. Keytruda Qlex Prescribing Information. Rahway, NJ: Merck and Co., Inc; July 2026. Available at: https://www.merck.com/product/usa/pi_circulars/k/keytruda_qlex/keytruda_qlex_pi.pdf. Accessed July 14, 2026.
3. Keytruda. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at https://www.nccn.org/professionals/drug_compendium/content/. Accessed May 25, 2026.
4. Keytruda Qlex. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at https://www.nccn.org/professionals/drug_compendium/content/. Accessed May 25, 2026.
5. Salem ME, Puccini A, Grothey A, et al. Landscape of tumor mutation load, mismatch repair deficiency, and PD-L1 expression in a large patient cohort of gastrointestinal cancers. Molecular cancer research: MCR. March 9, 2018;16(5):805-812. https://pubmed.ncbi.nlm.nih.gov/29523759/. Accessed May 25, 2026.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9271	Injection, pembrolizumab, 1 mg
J9277	Injection, pembrolizumab, 1 mg and berahyaluronidase alfa-pmph

Reviews, Revisions, and Approvals	Date	P&T Approval Date
RT4: for endometrial carcinoma for use in combination with Lenvima, revised dMMR to pMMR per updated FDA approved indication. Template changes applied to other diagnoses/indications.	08.23.22	
RT4: added criteria for newly FDA approved indication of single-agent adjuvant therapy for NSCLC, added "as determined by an FDA-	02.08.23	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
approved test" for MSI-H/dMMR cancer and microsatellite instability-high or mismatch repair deficient CRC, and revised "adult indications: additional dosing regimen" to apply only to adult cHL and PMBCL per updated PI; revised NSCLC criteria to include additional requirements related to mutation status per NCCN compendium; references reviewed and updated.		
RT4: added additional urothelial cancer indication in combination with enfortumab vedotin for patients ineligible for cisplatin-containing chemotherapy, and updated FDA approved indication for MSI-H/dMMR solid tumors to reflect full FDA approval per PI.	04.25.23	
3Q 2023 annual review: cHL, PMBCL, MSI-H/dMMR, MCC, TMB-H: adjusted pediatric age from 2 years to 6 months per PI/KEYNOTE-051; for Melanoma added option to be prescribed in combination with Mekinist and Trafinlar for disease with BRAF V600 activating mutation per NCCN; added endemic or classic Kaposi Sarcoma for adult off-label use and hypermutant tumor diffuse high-grade glioma for pediatric off-label use per NCNN; added criterion prescribed as single agent for Merkel cell carcinoma per NCCN; for HCC, added option for Stivarga; for pediatric PMBCL added option to be prescribed in combination with Adcetris; for endometrial carcinoma added option for combination with carboplatin and paclitaxel if disease is recurrent or stage III-IV tumor; references reviewed and updated.	05.16.23	08.23
RT4: updated FDA-approved indication for MCC to full FDA approval and added new indication of HER2-negative gastric/GEJ per PI; for NSCLC, criteria added for new FDA approved indication – "combination with platinum-containing chemotherapy as neoadjuvant therapy, then continued as single agent as adjuvant treatment after surgery for patients with tumors ≥ 4 cm or node positive" and option for disease to be resectable or resected per updated PI; added criteria for newly approved FDA indication for BTC per PI and NCCN; for gastric/esophageal/GEJ cancer, clarified specific uses per updated PI, including requirement that tumor must be HER2-positive and express PD-L1 (CPS ≥ 1) when prescribed in combination use with trastuzumab for gastric/GEJ adenocarcinoma; for MSI-H/dMMR, added gastric or GEJ cancer as cancer type that can be prescribed as first line or subsequent therapy and added option to prescribe in combination with platinum- and fluoropyrimidine-based chemotherapy for gastric or GEJ cancer per NCCN; for urothelial cancer in combination with Padcev, updated FDA-approved indication to full approval and removed requirement for cisplatin ineligibility per updated PI.	12.19.23	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
RT4: for cervical cancer, criteria added for new FDA indication for usage in combination with CRT with FIGO 2014 Stage III-IVA cancer.	01.17.24	
RT4: updated FDA-approved indication section for HCC to full approval with update from those "who have previously been treated with sorafenib" to "secondary to hepatitis B who have received prior systemic therapy other than a PD-1/PD-L1-containing regimen" per PI; for HCC, added option for prior use of Cabometyx and added option to be prescribed as first-line treatment per NCCN.	02.13.24	
3Q 2024 annual review: for cHL, added option to be prescribed with ICE and added pathway for palliative therapy (previously had after hematopoietic stem cell transplant, which falls under palliative therapy) per NCCN; for UC, added pathway to be prescribed as single agent and member has previously received other chemotherapy (previously only allowed post-platinum chemotherapy); for HCC, removed disease is classified as Child-Pugh Class A; for BTC, added option for resected gross residual (R2) disease and removed combination with Lenvima per NCCN; for endometrial carcinoma, clarified continued as a single agent for maintenance therapy when prescribed in combination with carboplatin and paclitaxel; for NCCN recommended uses (off-label): expanded to stage IB for mycosis fungoides, for prescribed as first-line or subsequent therapy - added metastatic anaplastic carcinoma, anaplastic sarcoma, and vaginal cancer, for prescribed as single-agent subsequent therapy – added soft tissue sarcoma subtypes, added option for Keytruda to be prescribed in combination with cyclophosphamide and bevacizumab for platinum-resistant persistent ovarian cancer, fallopian tube cancer, and primary peritoneal cancer per NCCN; for continuation requests, added criterion for maximum duration of therapy (previously was included within requests for dose increase criterion); updated appendix E; references reviewed and updated. RT4: added new FDA approved indication for endometrial cancer in combination with carboplatin and paclitaxel followed by Keytruda as a single agent per PI.	07.02.24	08.24
RT4: added new FDA approved indication for MPM.	09.30.24	
RT4: updated FDA Approved Indication section for EC in combination with lenvatinib to require FDA-approved testing for both MSI-H and pMMR (previously required for pMMR only) per PI.	02.13.25	
Per March SDC, for HNSCC, added redirection for nasopharyngeal carcinoma to Loqtorzi; added Appendix G to include states with regulations against redirections in cancer.	03.31.25	05.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
RT4: updated FDA Approved Indication(s) section for first-line treatment of adults with locally advanced unresectable or metastatic HER2-positive gastric or GEJ adenocarcinoma in combination with trastuzumab, fluoropyrimidine- and platinum-containing chemotherapy whose tumors express PD-L1 (CPS ≥ 1) from accelerated approval to full approval per PI; for gastric cancer, esophageal cancer, or GEJ cancer, added option to bypass disease is unresectable, locally advanced, recurrent, or metastatic if member is planned for esophagectomy per NCCN. Added step therapy bypass for IL HIM per IL HB 5395.		
3Q 2025 annual review: for NSCLC, updated targeted therapies for EGFR exon 19 deletion, L858R, and ROS1 rearrangement positive disease; for HNSCC added option to be prescribed in combination with Erbitux as first-line therapy or subsequent-line therapy; for cHL, added option to be prescribed in combination with decitabine and vorinostat, for post-allogenic hematopoietic cell transplant or post autologous stem cell rescue, and members not candidate for anthracycline therapy and revised for relapsed disease for both adults and pediatrics after ≥ 1 line of systemic therapy (previously ≥ 2 lines of systemic therapy for pediatrics); for UC, added option to be prescribed in combination with Inlyta or Lenvima, usage for relapsed disease, and prescribed as a single agent for adjuvant therapy; for cervical cancer, added FIGO 2018 stage III-IVA in combination with CRT and added option to be prescribed in combination with Tivdak for tumors expressing PD-L1 and has not received prior immune-oncology therapy, recurrent or metastatic disease, and disease as progressed on or after ≥ 1 line of systemic therapy; for HCC, removed specific treatment regimens member has had disease progression following from and revise to prescribed as subsequent line therapy; for BTC, added option for disease is resectable locoregionally advanced and prescribed as neoadjuvant therapy for gallbladder cancer; for TNBC, added option to be prescribed as preoperative systemic therapy in combination with carboplatin and docetaxel; added off-label usage for central nervous (CNS) cancer, thyroid carcinoma, peritoneal mesothelioma, penile cancer; for mycosis fungoides, revised stage to Stage IA – III; for thymic carcinoma, removed metastatic or unresectable requirement; RT4: updated FDA Approved Indication(s) section and criteria to reflect revised indication that limits use to tumors expressing PD-L1 (CPS ≥ 1) for esophageal or GEJ carcinoma in combination with chemotherapy and HER2-negative gastric or GEJ adenocarcinoma as first-line therapy in combination with chemotherapy per updated PI (previously approved regardless of PD-	07.01.25	08.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
L1 status); RT4: updated FDA Approved Indications(s) section for cervical cancer to clarify FIGO 2014 Stage III-IVA per updated PI; updated Appendix E with addition of soft tissue sarcoma as an example for MSI-H solid tumors and small bowel adenocarcinoma for TMB-H solid tumors; updated Appendix G with revised language and exception for Tennessee; references reviewed and updated. Per June SDC: added redirection to Tevimbra for HER2-negative gastric or GEJ adenocarcinoma and esophageal carcinoma or GEJ squamous cell carcinoma. RT4: added new FDA approved indication for usage in the neoadjuvant/adjuvant setting for locally advanced HNSCC.		
RT4: added new SC formulation Keytruda Qlex to policy; for Keytruda, converted FDA approved indication for 400 mg every 6-week dosing regimen in adults with cHL and PMBCL to full approval per PI; added step therapy bypass for IL HIM per IL HB 5395 for gastric cancer, esophageal cancer, and GEJ cancer.	09.26.25	
RT4: new indication for MIBC added per updated PI; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; HCPCS code [J3590] removed and HCPCS code [J9999] added.	12.02.25	
HCPCS code [C9399, J9999] removed and HCPCS code [J9277] added. RT4: added new indication for epithelial ovarian, fallopian tube, or primary peritoneal carcinoma per updated PI (previously off-label, now FDA-labeled).	02.20.26	
Updated Appendix G to include Indiana.	03.27.26	
RT4: updated FDA Approved Indication section with addition of FDA-approved test for esophageal or GEJ cancer whose tumors express PD-L1 (CPS ≥ 1) per updated PI; for Keytruda Qlex, added indication for usage in the neoadjuvant/adjuvant setting for locally advanced HNSCC per PI.	04.16.26	
3Q 2026 annual review: added ICHRA line of business; for urothelial carcinoma and MPM, removed requirement for locally advanced, relapsed, or metastatic disease; for NSCLC, added option to be prescribed as single-agent for those who have received previous adjuvant chemotherapy or neoadjuvant chemotherapy with pembrolizumab; for MSI-H/dMMR, added option for neoadjuvant systemic therapy for gallbladder cancer, gastric cancer, adenocarcinoma GEJ, and small bowel adenocarcinoma; for off-label anal carcinoma and vulvar cancer, added option to be prescribed in combination with paclitaxel and cisplatin/carboplatin; for off-label soft tissue sarcoma subtypes, added option to be prescribed as single-	07.14.26	08.26

Reviews, Revisions, and Approvals	Date	P&T Approval Date
agent for cutaneous angiosarcoma or dedifferentiated liposarcoma and as neoadjuvant or adjuvant therapy for UPS related sarcomas; for off-label vaginal cancer, added requirement for unresectable, metastatic or recurrent PD-L1-positive (CPS ≥ 1) disease; added the following off-label indications per NCCN: appendiceal neoplasms and cancers, recurrent conventional chordoma (including chondroid), dedifferentiated chondrosarcoma; CLL/SLL with histologic (Richter) transformation, and malignant histiocytic neoplasm; references reviewed and updated. Per June SDC, added redirection to Imfinzi for BTC. RT4: added the following new FDA-approved indications - combination use with belzutifan (Welireg) for adjuvant treatment of patients with ccRCC at intermediate-high or high risk of recurrence following nephrectomy, or following nephrectomy and resection of metastatic lesions, combination use with sacituzumab govitecan-hziy (Trodelvy) for first-line metastatic TNBC, and combination use with enfortumab vedotin-ejfv (Padcev) for perioperative treatment of adults with MIBC (regardless of cisplatin eligibility); for urothelial cancer, removed combination use with Inlyta or Lenvima and for treatment of BCG-unresponsive tumors removed requirement with CIS per NCCN; updated Appendix G with revised language for Tennessee.		

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.