Manulife

Group Benefits
Drug Prior Authorization

Keytruda (Pembrolizumab)

The purpose of this form is to obtain the medical information required to assess your request for a drug on the Prior Authorization list under your drug plan benefit coverage. To avoid delays in processing your request, please ensure that all information, including contact information is complete. Completion of this form is not a guarantee of approval. If you have already purchased the drug, please attach all original receipts along with an Extended Health Care Claim form. All costs incurred to complete this form are the plan member's responsibility. If you are registered for the Plan Member Secure Site and have provided an email address, you will receive an email notification when the prior authorization decision is available on your claims statement. If you are not registered on the Plan Member Secure Site, you will be notified of the prior authorization decision by mail.

Important: Please ensure the most current unaltered version of the form is completed and signed. To download the most recent version of the Drug Prior Authorization form go to www.manulife.ca.

1 – Plan member and patient information — To be completed by plan member

Plan contract number	Plan member certificate number	Plan sponsor

Plan member name (first)	Plan member name (middle initial)	Plan member name (last)	Plan member Date of birth (dd/mmm/yyyy)

Plan member address (number, street)	Address (suite)	City or town	Province	Postal code

Patient name (first)	Patient name (middle initial)	Patient name (last)	Patient date of birth (dd/mmm/yyyy)	Relationship to plan member

Patient's preferred daytime phone number	Patient's email address (optional)

1A – Other Group Plan

Does the patient have drug coverage under any other group plan? If Yes, please complete below: ☐ Yes ☐ No

Name of insurance company	
Plan contract number	Plan member certificate number

Is this drug covered under the other group plan? ☐ Yes ☐ No

If no, why was the drug declined by the other group plan? Please attach the other group plan decline notice (typically a letter or statement). We need this decline notice to see if this drug can be approved. If this is a renewal a current decline notice is required.

1B – Recent Coverage Change

Did your plan sponsor recently transfer your drug benefits to Manulife? ☐ Yes ☐ No

Before joining Manulife, were you receiving coverage for this drug through your previous insurance company ☐ Yes ☐ No

If Yes, attach proof of payment (a copy of a pharmacy receipt showing payment from prior insurance company or an Explanation of Benefits from the prior insurance company). Proceed to section 7.

2 – Provincial Plans — To be completed by plan member

Most provinces offer some form of drug coverage to their residents. Your Manulife drug plan supplements the coverage provided by provincial plans. It is important that you or your doctor (if required) apply to the applicable provincial program to ensure there are no delays in your drug reimbursement. Check with your doctor or login to the **Manulife Provincial Drug Plans Resource Centre** on our Plan Member Secure Site at www.manulife.ca/planmember to confirm if the drug you have been prescribed may be eligible for coverage under a provincial plan. If the drug you have been prescribed is listed under a provincial program, you will need to apply to the program before consideration can be given under your Manulife drug plan.

Has application been made to the provincial program for coverage? ☐ Yes ☐ No

If no, why?

Has the patient been approved for coverage by the provincial program for this drug? ☐ Yes ☐ No

If no, advise why the request was declined?

In Ontario, for patients that qualify for coverage under the Exceptional Access Program (EAP), if the drug is an EAP drug, a copy of the approval or denial from EAP must be submitted with this form so Manulife can complete the assessment of this request.

3 – Patient Assistance Programs — To be completed by plan member

Have you enrolled in the Patient Assistance Program for the requested drug? ☐ Yes ☐ No

If yes, please provide the details below:

Case Manager Name (first)	Case Manager name (last)	Case Manager Phone	Case Manager Email

Patient Assistance Program Name	Patient Assistance Program ID Number:

4 – Medical information — To be completed by prescribing physician

Drug strength and dosage

Where will treatment be administered?

☐ Home ☐ MD office ☐ Private Clinic ☐ Hospital/In-Patient ☐ Hospital/Out-patient

Is the MD office located in a hospital? ☐ Yes ☐ No

Will the drug be administered in the MD office or in another area of the hospital? (describe below)

If the treatment is not being administered at home, please provide:

Name of private clinic/hospital				Telephone number
Address (number, street)	Address (suite)	City or town	Province	Postal code

Please select the diagnosis for which the drug has been prescribed and respond to the corresponding questions.

☐ Unresectable or Metastatic Melanoma (ipilimumab naïve) - Initial Criteria

Has the patient had prior therapy with ipilimumab (Yervoy)? ☐ Yes ☐ No

Is the drug being administered under the supervision of physicians experienced in the treatment of cancer? ☐ Yes ☐ No

Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.

☐ Unresectable or Metastatic Melanoma (ipilimumab naïve) - Renewal Criteria

Is there evidence of disease progression while on Keytruda therapy? ☐ Yes ☐ No

Is drug being administered under the supervision of physicians experienced in the treatment of cancer? ☐ Yes ☐ No

Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.

☐ Unresectable or Metastatic Melanoma (previously treated with ipilimumab) - Initial Criteria

Has patient received at least 2 doses of ipilimumab (Yervoy) with the last dose being within the last 6 months? ☐ Yes ☐ No

Is there confirmation of disease progression following ipilimumab (Yervoy) therapy? ☐ Yes ☐ No

If BRAF V600 mutation is positive, is there confirmation of disease progression following therapy with a BRAF or MEK inhibitor? ☐ Yes ☐ No

Will drug be administered under the supervision of a physician experienced in the treatment of cancer? ☐ Yes ☐ No

Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.

☐ Unresectable or Metastatic Melanoma (previously treated with ipilimumab) - Renewal Criteria

Is there evidence of disease progression while on Keytruda therapy? ☐ Yes ☐ No

Will drug be administered under the supervision of a physician experienced in the treatment of cancer? ☐ Yes ☐ No

Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.

4 – Medical information (continued)	To be completed by prescribing physician

☐ **Adjuvant treatment of Stage IIB, IIC, III Melanoma**

Does patient have Stage IIB or IIIC melanoma?	☐ Yes	☐ No
Has patient had a complete resection?	☐ Yes	☐ No
Is drug being used as monotherapy?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approval is limited to maximum of 12 months.

☐ **Non-Small Cell Lung Carcinoma (NSCL) (1st line therapy) - Initial Criteria**

Will drug be is used as monotherapy?	☐ Yes	☐ No
Does patient have Stage III or metastatic non-small cell lung carcinoma (NSCLC)?	☐ Yes	☐ No
Has patient received prior systemic chemotherapy treatment for metastatic NSCLC?	☐ Yes	☐ No
Is patient a candidate for surgical resection or definitive chemoradiation?	☐ Yes	☐ No
Is patient's tumours express PDL-1 (Tumour Proportion Score (TPS≥1%)]?	☐ Yes	☐ No
Does patient have EGFR or ALK tumour aberrations?	☐ Yes	☐ No
Will drug be administered under the supervision of a physician experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.

☐ **Non-Small Cell Lung Carcinoma (NSCL) (1st line therapy) - Renewal Criteria**

Is there evidence of disease progression while on Keytruda therapy?	☐ Yes	☐ No
Will drug be administered under the supervision of a physician experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.

☐ **Non-Small Cell Lung Carcinoma (NSCL) (2nd line therapy) - Initial Criteria**

Will drug be is used as monotherapy?	☐ Yes	☐ No
Is patient's tumours express PDL-1 (Tumour Proportion Score (TPS≥1%)]?	☐ Yes	☐ No
Has patient progressed on or after platinum-containing chemotherapy?	☐ Yes	☐ No
Does patient have EGFR or ALK tumour aberrations?	☐ Yes	☐ No
Has patient received authorized therapy for these aberrations prior to receiving Keytruda?	☐ Yes	☐ No
Will drug be administered under the supervision of a physician experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.

☐ **Non-Small Cell Lung Carcinoma (NSCL) (2nd line therapy) - Renewal Criteria**

Is there evidence of disease progression while on Keytruda therapy?	☐ Yes	☐ No
Will drug be administered under the supervision of a physician experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.

4 – Medical information (continued)	To be completed by prescribing physician

☐ **Non-squamous Non-Small Cell Lung Carcinoma (NSCL) - Initial Criteria**

Has patient been pathologically confirmed with metastatic non-squamous NSCLC?	☐ Yes	☐ No
Has patient received any prior systemic therapy for metastatic disease?	☐ Yes	☐ No
Will drug be used in combination with pemetrexed and platinum chemotherapy?	☐ Yes	☐ No
Does patient have EGFR or ALK genomic tumour aberrations?	☐ Yes	☐ No
Will drug be administered under the supervision of a physician experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.

☐ **Non-squamous Non-Small Cell Lung Carcinoma (NSCL) - Renewal Criteria**

Is there evidence of disease progression while on Keytruda therapy?	☐ Yes	☐ No
Will drug be administered under the supervision of a physician experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.

☐ **Squamous Non-Small Cell Lung Carcinoma (NSCL) - Initial Criteria**

Has patient received any prior systemic therapy for metastatic disease?	☐ Yes	☐ No
Will drug be used in combination with carboplatin and paclitaxel or nab-paclitaxel?	☐ Yes	☐ No
Will drug be administered under the supervision of a physician experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.

☐ **Squamous Non-Small Cell Lung Carcinoma (NSCL) - Renewal Criteria**

Is there evidence of disease progression while on Keytruda therapy?	☐ Yes	☐ No
Will drug be administered under the supervision of a physician experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approvals for prior authorization drugs may be subject to a time limitation. If applicable, you will be required to provide additional information to Manulife to assess continued coverage. You will be advised of the approval duration at the time of approval.

☐ **Urothelial Carcinoma (platinum therapy ineligible) - Initial Criteria**

Does patient have locally advanced unresectable or metastatic urothelial carcinoma?	☐ Yes	☐ No
Is patient eligible for any platinum-containing chemotherapy?	☐ Yes	☐ No
Will drug be used as monotherapy?	☐ Yes	☐ No
Will drug be administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ **Urothelial Carcinoma (platinum therapy ineligible) - Renewal Criteria**

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Will drug be used as monotherapy?	☐ Yes	☐ No
Will drug be administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approval is limited to 12 additional months for 24 months maximum.

4 – Medical information (continued)	To be completed by prescribing physician

☐ Urothelial Carcinoma (previously treated) - Initial Criteria

Does patient have locally advanced or metastatic urothelial carcinoma?	☐ Yes	☐ No
Does patient have disease progression during or following platinum-containing chemotherapy?	☐ Yes	☐ No
Does patient have disease progression within 12 months of completing neoadjuvant or adjuvant platinum-containing chemotherapy?	☐ Yes	☐ No
Will drug will be used as monotherapy?	☐ Yes	☐ No
Will drug be administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ Urothelial Carcinoma (previously treated) - Renewal Criteria

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Will drug be administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approval is limited to 12 additional months for 24 months maximum.

☐ Bacillus Calmette-Guerin (BCG)-unresponsive, high-risk, non-muscle invasive bladder cancer (NMIBC) - Initial Criteria

Is the bladder cancer Bacillus Calmette-Guerin (BCG)-unresponsive?	☐ Yes	☐ No
Is the bladder cancer high risk?	☐ Yes	☐ No
Does the patient have carcinoma in-situ (CIS) with or without papillary tumours?	☐ Yes	☐ No
Is the patient ineligible for or have they elected not to undergo cystectomy?	☐ Yes	☐ No
Is bladder cancer considered to be non-muscle invasive?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ Bacillus Calmette-Guerin (BCG)-unresponsive, high-risk, non-muscle invasive bladder cancer (NMIBC) - Renewal Criteria

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

☐ Hodgkin Lymphoma - Initial Criteria

Does the patient have refractory or relapsed classical Hodgkin Lymphoma (cHL)?	☐ Yes	☐ No
Will Keytruda be used as monotherapy?	☐ Yes	☐ No
Has the patient failed autologous stem cell transplant (ASCT)?	☐ Yes	☐ No
Is the patient a candidate for multiagent salvage chemotherapy and ASCT?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ Hodgkin Lymphoma - Renewal Criteria

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Is Keytruda being used as monotherapy?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

4 – Medical information (continued)	To be completed by prescribing physician

☐ Primary Mediastinal B-cell Lymphoma (PMBCL) - Initial Criteria

Has the patient relapsed after 2 or more lines of therapy for primary mediastinal B-cell lymphoma?	☐ Yes	☐ No
Is Keytruda being used as monotherapy?	☐ Yes	☐ No
Does patient have refractory primary mediastinal B-cell lymphoma (PMBCL)?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ Primary Mediastinal B-cell Lymphoma (PMBCL) - Renewal Criteria

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Is Keytruda being used as monotherapy?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

☐ Colorectal Cancer (CRC) - Initial Criteria

Does the patient have metastatic MSI-H or dMMR colorectal cancer (CRC)?	☐ Yes	☐ No
Is Keytruda being used as monotherapy?	☐ Yes	☐ No
Is Keytruda being used as first-line treatment?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ Colorectal Cancer (CRC) - Renewal Criteria

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Is Keytruda being used as monotherapy?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

☐ Microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer or endometrial cancer - Initial Criteria

Will Keytruda be used as monotherapy?	☐ Yes	☐ No
Is cancer unresectable or metastatic?	☐ Yes	☐ No
Does the patient have MSI-H or DMMR colorectal cancer?	☐ Yes	☐ No
If yes, has there been progression following treatment with a fluopyrimidine, oxaliplatin and irinotecan?	☐ Yes	☐ No
Does the patient have NSI-H or DMMR endometrial cancer?	☐ Yes	☐ No
If yes, has there been progression following prior therapy?	☐ Yes	☐ No
Are there any other satisfactory treatment options?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ Microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer or endometrial cancer - Renewal Criteria

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Is Keytruda being used as monotherapy?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

4 – Medical information (continued)	To be completed by prescribing physician

☐ **Advanced Endometrial Carcinoma (combination with levatinib mesylate) - Initial Criteria**

Is the endometrial cancer microsatellite instability-high (MSI-H), or mismatch repair deficient (dMMR)?	☐ Yes	☐ No
Has patient had disease progression following prior platinum-based systemic therapy?	☐ Yes	☐ No
Is the patient a candidate for curative surgery or radiation?	☐ Yes	☐ No
Will drug be taken in combination with Lenvima (levatinib mesylate)?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ **Advanced Endometrial Carcinoma (combination with levatinib mesylate) - Renewal Criteria**

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

☐ **Renal Cell Carcinoma (RCC) (combination with axitinib) - Initial Criteria**

Is the Renal Cell Carcinoma advanced or metastatic?	☐ Yes	☐ No
Will drug be used in combination with axitinib (Inlyta)?	☐ Yes	☐ No
Has patient received prior systemic therapy for metastatic RCC?	☐ Yes	☐ No
Does patient have good performance status (ECOG ≤ 2)?	☐ Yes	☐ No
Will drug be administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ **Renal Cell Carcinoma (RCC) (combination with axitinib) - Renewal Criteria**

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Will drug be administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approval is limited to 12 additional months for 24 months maximum.

☐ **Renal Cell Carcinoma (RCC) (combination with lenvatinib) - Initial Criteria**

Will the drug be taken in combination with Lenvima?	☐ Yes	☐ No
Has the patient had prior systemic therapy for metastatic RCC?	☐ Yes	☐ No
Does patient have advanced (not amenable to curative surgery or radiation) or metastatic RCC?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ **Renal Cell Carcinoma (RCC) (combination with lenvatinib) - Renewal Criteria**

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

☐ **Renal Cell Carcinoma (RCC) (monotherapy)**

Will Keytruda be used as monotherapy?	☐ Yes	☐ No
Has patient had a nephrectomy, or a nephrectomy and resection of metastatic lesions, and they are at intermediate-high or high-risk of recurrence?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approval is limited to maximum of 12 months.

4 – Medical information (continued)	To be completed by prescribing physician

☐ **Head and Neck Squamous Cell Carcinoma (HNSCC) - Initial Criteria**

Will Keytruda be used first-line?	☐ Yes	☐ No
Will Keytruda be used as monotherapy?	☐ Yes	☐ No
If yes, will it be used in tumours that have PD-L1 expression [Combined Positive Score (CPS) >= 1] as determined by a validated test?	☐ Yes	☐ No
Will Keytruda be used or in combination with platinum and fluorouracil (FU) chemotherapy?	☐ Yes	☐ No
Has patient received any prior systemic therapy for metastatic or unresectable recurrent HNSCC?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ **Head and Neck Squamous Cell Carcinoma (HNSCC) - Renewal Criteria**

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

☐ **Biliary Tract Carcinoma (BTC) - Initial Criteria**

Does patient have locally advanced unresectable or metastatic disease?	☐ Yes	☐ No
Will drug be used in combination with gemcitabine-based chemotherapy?	☐ Yes	☐ No
Will drug be administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ **Biliary Tract Carcinoma (BTC) - Renewal Criteria**

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Will drug be administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approval is limited to 12 additional months for 24 months maximum.

☐ **Esophageal Cancer - Initial Criteria**

Will drug be used in combination with platinum and fluoropyrimidine based chemotherapy?	☐ Yes	☐ No
Is Keytruda being used as first-line treatment?	☐ Yes	☐ No
Does patient have locally advanced unresectable or metastatic carcinoma of the esophagus OR HER2 negative adenocarcinoma of the esophagogastric junction (tumor center 1 to5 cm above the gastric cardia)?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ **Esophageal Cancer - Renewal Criteria**

Does the patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

☐ **Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma, HER2 negative - Initial Criteria**

Does patient have locally advanced unresectable or metastatic HER2-negative gastric or gastroesophageal junction (GEJ) adenocarcinoma?	☐ Yes	☐ No
Will drug be used in combination with platinum and fluoropyrimidine based chemotherapy?	☐ Yes	☐ No
Will drug be used as first-line treatment?	☐ Yes	☐ No
Will drug be administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

4 – Medical information (continued)	To be completed by prescribing physician

☐ Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma, HER2 negative - Renewal Criteria

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Will drug be administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approval is limited to 12 additional months for 24 months maximum.

☐ High-Risk Early-Stage Triple-Negative Breast Cancer (TNBC)

Is the patient using this medication in combination with chemotherapy as neoadjuvant treatment?	☐ Yes	☐ No
Is the patient using this medication as continued monotherapy as adjuvant treatment after surgery?	☐ Yes	☐ No
Is patient at high-risk early-stage triple-negative breast cancer (TNBC)?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Approval is limited to maximum of 12 months.

☐ Recurrent unresectable or metastatic Triple-Negative Breast Cancer (TNBC) - Initial Criteria

Will drug be used in combination with chemotherapy?	☐ Yes	☐ No
Has patient received prior chemotherapy for metastatic disease?	☐ Yes	☐ No
Are the patient's tumors express PDL1 (Combined positive score (CPS)>= 10) as determined by a validated test?	☐ Yes	☐ No
Does patient have locally recurrent unresectable or metastatic triple-negative breast cancer (TNBC)?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ Recurrent unresectable or metastatic Triple-Negative Breast Cancer (TNBC) - Renewal Criteria

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

☐ Cervical Cancer (persistent, recurrent, or metastatic) - Initial Criteria

Is the patient using this medication in combination with chemotherapy either with or without bevacizumab?	☐ Yes	☐ No
Does patient have persistent, recurrent, or metastatic cervical cancer?	☐ Yes	☐ No
Does patient's tumours express PD-L1 (CPS ≥ 1)?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

Note: Initial approval is limited to 12 months. Additional information is required after 12 months, in order to assess for further coverage. Maximum treatment duration is 24 months.

☐ Cervical Cancer (persistent, recurrent, or metastatic) - Renewal Criteria

Does patient show evidence of progression of disease while on Keytruda therapy?	☐ Yes	☐ No
Is drug being administered under the supervision of physicians experienced in the treatment of cancer?	☐ Yes	☐ No

☐ Any Other Diagnosis

Please provide the specific diagnosis and any Canadian clinical research that supports the use of this drug in your patient's context.

5 – Drug history — To be completed by prescribing physician

If no previous therapies have been tried for the selected diagnosis, please specify the rationale:

☐ Risk of drug interaction ☐ Patient has contraindication

☐ Other

Please provide medical rationale

For the selected diagnosis, please provide all previous and current drug therapies in the area below:

Drug name	Start date (yyyy/mmm)	End date (yyyy/mmm)	Specify Outcome:
			☐ Intolerance (Allergy/Adverse Event) ☐ Inadequate/Suboptimal Response
Will the patient be continuing this medication in addition to new therapy?			☐ Yes ☐ No
Drug name	**Start date (yyyy/mmm)**	**End date (yyyy/mmm)**	**Specify Outcome:** ☐ Intolerance (Allergy/Adverse Event) ☐ Inadequate/Suboptimal Response
Will the patient be continuing this medication in addition to new therapy?			☐ Yes ☐ No
Drug name	**Start date (yyyy/mmm)**	**End date (yyyy/mmm)**	**Specify Outcome:** ☐ Intolerance (Allergy/Adverse Event) ☐ Inadequate/Suboptimal Response
Will the patient be continuing this medication in addition to new therapy?			☐ Yes ☐ No
Drug name	**Start date (yyyy/mmm)**	**End date (yyyy/mmm)**	**Specify Outcome:** ☐ Intolerance (Allergy/Adverse Event) ☐ Inadequate/Suboptimal Response
Will the patient be continuing this medication in addition to new therapy?			☐ Yes ☐ No
Drug name	**Start date (yyyy/mmm)**	**End date (yyyy/mmm)**	**Specify Outcome:** ☐ Intolerance (Allergy/Adverse Event) ☐ Inadequate/Suboptimal Response
Will the patient be continuing this medication in addition to new therapy?			☐ Yes ☐ No

6 – Physician information — To be completed by prescribing physician

Prescribing physician’s name (first)	Prescribing physician’s name (last)	College/License Number	Specialty

Address (number, street)	Address (suite)

City or town	Province	Postal code

Telephone number	Extension	Fax number

Physician authorization

I certify that the information in this form is true and complete to the best of my knowledge. The information in this statement will be kept in a Group Benefits health file with Manulife and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein.

Physician Signature	Date (dd/mmm/yyyy)

7 – Authorization and Plan member signature — To be signed by plan member

I certify that I, my spouse and/or my dependents of minor or major age ("Dependents") require the drug named on this form (or an equivalent drug that Manulife proposes).

I authorize:

Manulife and/or its service providers, its reinsurers, and their service providers to collect, use, maintain and disclose my personal information related to this application ("Personal Information") for the purposes of:

- The assessment of the drug authorization request
- Managing my Group Benefits plan
- Assessing and processing claims
- Auditing and investigation of claims
- Patient assistance programs, if applicable
- And/or other purposes identified in the Personal Information Statement for Employers' Group Benefits plans (collectively, the "Purposes").

Any person or organization who has Personal Information about me that is required for Manulife to assess this drug authorization request, including any medical and health care professionals, institution, pharmacy or any other medical or health care related facility, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any other administrators of other benefits programs to collect, use, maintain, disclose and exchange this information with each other and with Manulife, its reinsurers and/or its service providers, for the Purposes.

I understand:

- A Manulife approved pharmacy vendor may engage me in the capacity of case management to provide support as part of this program. I acknowledge that participation in this program is entirely voluntary. My decision to participate will not have any impact on the assessment of my claim.
- If my Manulife plan recommends purchasing a drug that requires prior authorization from a preferred pharmacy or provider, a case manager may contact me, my doctor and/or patient assistance program to arrange to have my prescription(s) transferred to the preferred pharmacy or provider.
- That except where there are contractual restrictions, Manulife employees, authorized organizations, service providers and reinsurers are located both within Canada and outside of Canada. Therefore, my Personal Information may be subject to interprovincial or cross-border transfers for the Purposes and may be subject to the laws of those jurisdictions.
- I may withdraw my consent for certain uses of my Personal Information, subject to legal and contractual restrictions. If I do so, Manulife may treat my withdrawal of consent as a request to dismiss, rescind or terminate my claim.

I agree:

- A photocopy or electronic version of this consent is valid.
- I have the right to access and verify my Personal Information maintained in Manulife's files and to request any factually inaccurate Personal Information be corrected, if appropriate.
- Requests can be sent to: Privacy Officer Manulife, P.O. Box 1602, Del Stn 500-4-A, Waterloo, Ontario N2J 4C6 or Canada_Privacy@manulife.ca
- For more information, I can review the Personal Information Statement for Employers' Group Benefits Plans and the Canadian Privacy Policy.

I confirm that:

- The information I have given in this request is true and accurate.
- By signing, I give permission to and/or confirm that I have obtained the individual's consent for the collection, use, disclosure or otherwise processing of the individual's Personal Information for the Purposes (as these terms are defined above).

Plan member's signature	Date signed (dd/mmm/yyyy)

Protecting your personal information is important to us. People who can see your personal information are:

- Manulife employees who need to see your information to do their jobs.
- People you've given permission to.

To find out more about Manulife's privacy policy please see manulife.ca

8 – Submission instructions

Plan Member Secure Site

1. Log in to the **Plan Member Secure Site**.
2. Choose **"Claims"**
3. Go to **"Submit a Claim."**
4. Under **Service Provider**, select **"Other."**
5. Choose **"Estimate"** as the **Claim Type**.

Mobile App Site

1. Open the **Mobile Site** on your device.
2. Select **"Submit a Claim."**
3. Choose **"Estimate"** as the **Claim Type**.

Mail or fax

If you live in Quebec:
Manulife Group Benefits Health Claims
Attention Prior Authorization Team
PO BOX 2580, STATION B
MONTREAL QC H3B 5C6

Fax: 1-855-752-0404

If you live outside Quebec:
Manulife Group Benefits Health Claims
Attention Prior Authorization Team
PO BOX 1653
WATERLOO ON N2J 4W1

Fax: 1-855-752-0404

Please retain a photocopy for your files.