

Tecentriq® (Atezolizumab) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Physician billing (HCPCS code: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

Billing Provider Information

Provider NPI: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization:

1. Please indicate the diagnosis and information:

Non-Squamous Non-Small Cell Lung Cancer (NSCLC)

A. Will atezolizumab be used as first-line therapy for metastatic disease? Yes ___ No ___

B. Does member have epidermal growth factor receptor (EGFR), anaplastic lymphoma kinase (ALK), ROS1, BRAF, MET exon 14 skipping, or RET mutations? Yes ___ No ___

C. Will atezolizumab be used in combination with bevacizumab, paclitaxel, and carboplatin?
Yes ___ No ___

i. If yes to the above question, please indicate the number of cycles: _____

D. Will atezolizumab be used in combination with paclitaxel (protein bound) and carboplatin?
Yes ___ No ___

Non-Small Cell Lung Cancer (NSCLC)

A. Will atezolizumab be used as first-line therapy for metastatic disease? Yes ___ No ___

i. If yes, will atezolizumab be used as a single-agent? Yes ___ No ___

ii. If yes, does member have EGFR, ALK, ROS1, BRAF, MET exon 14 skipping, or RET mutations? Yes ___ No ___

iii. If yes, does disease have high programmed death ligand-1 (PD-L1) expression determined by the following [check applicable box(es)]?

PD-L1 stained >50% of tumor cells (TC>50%)

PD-L1 stained tumor-infiltrating immune cells (IC) covering >10% of the tumor area (IC>10%)

B. Will atezolizumab be used for subsequent therapy for metastatic disease? Yes ___ No ___

A. If yes, will atezolizumab be used as a single-agent? Yes ___ No ___

C. Is diagnosis stage 2 or 3A NSCLC? Yes ___ No ___

i. If yes, has member has undergone resection and completed platinum-based chemotherapy?
Yes ___ No ___

ii. Is PD-L1 expression $\geq 1\%$ of tumor cells? Yes ___ No ___

Small Cell Lung Cancer (SCLC)

A. Will atezolizumab be used as first-line therapy? Yes ___ No ___

B. Does member have extensive-stage disease? Yes ___ No ___

C. Will atezolizumab be used in combination with carboplatin and etoposide? Yes ___ No ___

Page 1 of 2

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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State of Oklahoma
SoonerCare

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Member Name: _____ Date of Birth: _____ Member ID#: _____

Criteria

Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization, continued:

1. Please indicate the diagnosis and information, continued:

Hepatocellular Carcinoma (HCC)

A. Is diagnosis advanced, unresectable, or metastatic HCC? Yes _____ No _____

B. Will atezolizumab be used in combination with bevacizumab? Yes _____ No _____

C. Has member received prior systemic therapy? Yes _____ No _____

Melanoma

A. Is diagnosis unresectable or metastatic melanoma? Yes _____ No _____

B. Is disease BRAF V600 mutation-positive? Yes _____ No _____

C. Will atezolizumab be used in combination with cobimetinib and vemurafenib? Yes _____ No _____

Alveolar Soft Part Sarcoma (ASPS)

A. Is ASPS unresectable or metastatic? Yes _____ No _____

If diagnosis is not previously listed, please indicate diagnosis: _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____

2. Does member have any evidence of progressive disease while on atezolizumab? Yes _____ No _____

i. If "No" to the above question, was atezolizumab used in combination with bevacizumab, paclitaxel, and carboplatin for non-squamous NSCLC? Yes _____ No _____

ii. If used in combination with bevacizumab, paclitaxel, and carboplatin for non-squamous NSCLC, how many cycles has the member received? _____

iii. Will atezolizumab be used in combination with bevacizumab for continued treatment? Yes _____ No _____

3. Has the member experienced adverse drug reactions related to atezolizumab therapy? Yes _____ No _____

i. If yes, please specify adverse reactions: _____

Additional Information: _____

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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