OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare

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____
   i. If yes, will atezolizumab be used as a single-agent? 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____

❑ **Urothelial Carcinoma**

A. Is diagnosis locally advanced or metastatic urothelial carcinoma? Yes____ No____
B. Did disease progress on or following platinum containing chemotherapy? Yes____ No____
C. Is member ineligible for cisplatin? Yes____ No____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

OKLAHOMA Health Care Authority

State of Oklahoma
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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____
   - ❑ **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.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*