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 ☐

❑ **Breast Cancer**
- A. Is diagnosis unresectable locally advanced or metastatic triple-negative breast cancer? Yes ☐ No ☐
- B. Will atezolizumab be used in combination with nab-paclitaxel (Abraxane®)? Yes ☐ No ☐
- C. Does member have positive expression of PD-L1? Yes ☐ No ☐
- D. Has member failed other immunotherapy(ies)? 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

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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:
   - ❑ **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 ☐
   - ❑ **Hepatocellular Carcinoma (HCC)**
     - A. Is diagnosis 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 ☐

If yes, please specify adverse reactions: _____

Additional Information: _____

_____

Please complete and return all pages. Failure to complete all pages will result in processing delays.

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.*

OHCA Approved – 10/05/2020