aetna®

Tecentriq™ (atezolizumab) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Oncologist** ☐ **Hematologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
Address: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Tecentriq (atezolizumab)**: Dose:** _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):
☐ Yes ☐ No Will Tecentriq (atezolizumab) be used as a single agent?
☐ Yes ☐ No Will Tecentriq (atezolizumab) be given as subsequent therapy?
☐ Yes ☐ No Has the patient had disease progression following treatment with an anti-PD 1 therapy agent (e.g. Tecentriq (atezolizumab), Opdivo (nivolumab), Keytruda (pembrolizumab),Bavencio (avelumab), or Imfinzi (durvalumab)?

For bladder urothelial cancer:
Please indicate the clinical stage of the disease: ☐ TX-T1, NX-3, M0 ☐ T2-T4a, N1-3, M0 ☐ T4b, NX-3, M0 ☐ Other: _____
☐ Yes ☐ No Is the patient being treated for recurrence post cystectomy or metastatic disease? ☐ Recurrence post cystectomy ☐ Metastatic disease
☐ Yes ☐ No Will Tecentriq (atezolizumab) be used for first-line treatment?
☐ Yes ☐ No Is the patient cisplatin-ineligible?

For non-small cell lung cancer:
☐ Yes ☐ No Is the patient's cancer metastatic in nature?
☐ Yes ☐ No Has the patient been previously treated with Keytruda (pembrolizumab)?
☐ Yes ☐ No Will Tecentriq (atezolizumab) be given following progression on a first-line cytotoxic regimen?
→ Please provide the name(s) of the previous regimen/ treatment: _____
☐ Yes ☐ No Will Tecentriq (atezolizumab) be given for further disease progression on other systemic therapy?
→ Please provide the name(s) of the previous regimen/ treatment: _____
Please indicate the patient's ECOG performance status: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For primary urothelial carcinoma of the urethra:

Please indicate how Tecentriq (atezplizumab) will be used: ☐ First-line/primary treatment ☐ Subsequent systemic therapy

☐ Yes ☐ No Is the patient cisplatin-ineligible?

☐ Yes ☐ No Does the patient have recurrent or metastatic disease?

→ Please indicate the clinical stage of the disease: ☐ Tis-2, cNO, M0 ☐ T3-4, cN1-2, M0 ☐ cN1-2 palpable inguinal lymph nodes

For upper genitourinary tract urothelial cancers:

☐ Yes ☐ No Does the patient have metastatic disease?

☐ Yes ☐ No Will Tecentriq (atezolizumab) be used for first-line treatment?

☐ Yes ☐ No Is the patient cisplatin-ineligible?

For urothelial carcinoma of the prostate:

☐ Yes ☐ No Does the patient have metastatic disease?

☐ Yes ☐ No Will Tecentriq (atezolizumab) be used for first-line treatment?

☐ Yes ☐ No Is the patient cisplatin-ineligible?

For Continuation Requests:

☐ Yes ☐ No Has the patient experienced disease progression while on Tecentriq (atezolizumab)?

☐ Yes ☐ No Has the patient developed an unacceptable toxicity to Tecentriq (atezolizumab)?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.