Tecentriq™ (atezolizumab) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
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 ☐ 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 Initiation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Has the patient experienced disease progression while receiving another programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor (e.g., Tecentriq (atezolizumab),Opdivo (nivolumab), Keytruda (pembrolizumab), Bavencio (avelumab), or Imfinzi (durvalumab)?

☐ **Bladder urothelial carcinoma**
☐ Yes ☐ No Will the requested medication be used as a single agent?
Will the requested medication be used as first-line systemic or subsequent systemic therapy? ☐ First-line therapy ☐ Subsequent systemic therapy
Please identify the clinical setting in which the requested medication will be used:
☐ Stage II or Stage III disease
→ ☐ Yes ☐ No Was the tumor present following reassessment 2-3 months after primary treatment with concurrent chemotherapy?
☐ Locally advanced disease
☐ Local recurrence post-cystectomy
☐ Metastatic disease
☐ Metastatic disease post-cystectomy
☐ Muscle invasive local recurrence or persistent disease in a preserved bladder
☐ Yes ☐ No Is the patient eligible for cisplatin chemotherapy?
☐ Yes ☐ No ☐ Unknown Does the patient's tumor express PD-L1 (defined as PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 5% of the tumor area)?
→ ☐ Yes ☐ No Is the patient eligible for any platinum-containing chemotherapy?
☐ Other, please explain: _____

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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.

☐ **Breast cancer**
- ☐ Yes ☐ Will the requested medication be used in combination with protein-bound paclitaxel?
- Please indicate the clinical setting: ☐ Unresectable locally advanced disease ☐ Metastatic disease ☐ Recurrent disease ☐ Other, please explain: _____
- ☐ Yes ☐ No ☐ Unknown Does the tumor express programmed death ligand 1 (PD-L1) (i.e., PD-L1 stained tumor-infiltrating immune cells [IC] of any intensity covering at least 1 percent of the tumor area)?
- ☐ Yes ☐ No ☐ Unknown Has the patient's diagnosis confirmed by the breast cancer cells testing negative for ALL of the following receptors?
  - → ☐ Human epidermal growth factor receptor 2 (HER2) ☐ Estrogen ☐ Progesterone

☐ **Hepatocellular carcinoma (HCC)**
- ☐ Yes ☐ No Will the requested medication be used in combination with bevacizumab?
- ☐ Yes ☐ No Will the requested medication be used for initial treatment?

☐ **Melanoma**
- Please indicate the clinical setting in which the requested medication will be used: ☐ Unresectable disease ☐ Metastatic disease ☐ Other, please explain: _____
- ☐ Yes ☐ No ☐ Unknown Is the tumor positive for BRAF V600 mutation?
- ☐ Yes ☐ No Will the requested medication be used in combination with cobimetinib (Cotellic) and vemurafenib (Zelboraf)?

☐ **Non-small cell lung cancer (NSCLC)**
- Please indicate if the patient has recurrent, advanced or metastatic disease: ☐ Recurrent disease ☐ Advanced disease ☐ Metastatic disease
- Please indicate the setting in which the requested medication will be used:

As subsequent therapy:
- ☐ Yes ☐ No Will the requested medication be used as subsequent therapy?
- ☐ Yes ☐ No Will the requested medication be used as a single agent?

Treatment for High PD-L1 expression:
- ☐ Yes ☐ No Will the requested medication be used as a single agent?
- ☐ Yes ☐ No Does the patient's tumor have high PD-L1 expression (PD-L1 stained≥ 50% of tumor cells [TC ≥ 50%] or PD-L1 stained tumor-infiltrating immune cells [IC] covering ≥ 10% of the tumor area [IC ≥ 10%])?
- ☐ Yes ☐ No Will the requested medication be used as first line treatment?
- ☐ Yes ☐ No Is the patient's disease positive for EGFR or ALK genomic tumor aberrations?

As combination therapy:
- ☐ Yes ☐ No Will the requested medication be used in combination with carboplatin, paclitaxel and bevacizumab?
- ☐ Yes ☐ No Will the requested medication be used in combination with carboplatin and paclitaxel protein-bound?
- ☐ Yes ☐ No Does the patient's disease have EGFR or ALK genomic tumor aberrations?
  - → ☐ Yes ☐ No Did the patient receive previous treatment that targeted the EGFR or ALK genomic tumor aberrations?
- Please indicate the tumor's histology: ☐ Non-squamous ☐ Squamous ☐ Unknown

☐ **Primary carcinoma of the urethra (Urothelial carcinoma)**
- ☐ Yes ☐ No Will the requested medication be given as a single agent?
- Please indicate the clinical setting in which the requested medication will be used: ☐ Recurrent disease ☐ Locally advanced disease ☐ Metastatic disease ☐ Other, please explain: _____
- Will the requested medication be used as first-line systemic or subsequent systemic therapy? ☐ First-line therapy ☐ Subsequent therapy
- ☐ Yes ☐ No Is the patient eligible for cisplatin chemotherapy?
- ☐ Yes ☐ No ☐ Unknown Does the patient's tumor express PD-L1 (defined as PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 5% of the tumor area)?
  - → ☐ Yes ☐ No Is the patient eligible for any platinum-containing chemotherapy?

☐ **Small cell lung cancer (small cell carcinoma)**
- ☐ Yes ☐ No Does the patient have extensive-stage disease?
- ☐ Yes ☐ No Will the requested medication be used in combination with etoposide and carboplatin (followed by single agent maintenance)?
- ☐ Yes ☐ No Will the requested medication be used for initial treatment?

☐ **Upper genitourinary (GU) tract tumors (Urothelial carcinoma)**
- ☐ Yes ☐ No Will the requested medication be given as a single agent?
- Please indicate the clinical setting in which the requested medication will be used: ☐ Locally advanced disease ☐ Metastatic disease ☐ Other, please explain: _____
- Please indicate the place in therapy in which the requested medication will be used: ☐ First-line therapy ☐ Subsequent therapy
- ☐ Yes ☐ No Is the patient eligible for cisplatin chemotherapy?
- ☐ Yes ☐ No ☐ Unknown Does the patient's tumor express PD-L1 (defined as PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 5% of the tumor area)?
  - → ☐ Yes ☐ No Is the patient eligible for any platinum-containing chemotherapy?

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

☐ **Urothelial carcinoma of the prostate**

☐ Yes ☐ No Will the requested medication be given as a single agent?

Please indicate the clinical setting in which the requested medication will be used: ☐ Locally advanced disease ☐ Metastatic disease ☐ Other, please explain: _____

Please indicate the place in therapy in which the requested medication will be used: ☐ First-line therapy ☐ Subsequent therapy

☐ Yes ☐ No Is the patient eligible for cisplatin chemotherapy?

☐ Yes ☐ No ☐ Unknown Does the patient's tumor express PD-L1 (defined as PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 5% of the tumor area)?

→ ☐ Yes ☐ No Is the patient eligible for any platinum-containing chemotherapy?

For Continuation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Has the patient experienced disease progression while receiving another programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor (e.g., Tecentriq (atezolizumab),Opdivo (nivolumab), Keytruda (pembrolizumab), Bavencio (avelumab), or Imfinzi (durvalumab)?

☐ Yes ☐ No Has the patient experienced disease progression while on the requested medication?

☐ Yes ☐ No Has the patient developed an unacceptable toxicity to the requested medication?

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

→ ☐ Yes ☐ No Is the patient continuing on a maintenance regimen that includes provider administered combination chemotherapy including but not limited to the following?

→ ☐ The requested medication will be used in combination with bevacizumab for non-small cell lung cancer (NSCLC)
☐ The requested medication will be used in combination with paclitaxel protein-bound for breast cancer
☐ Another combination chemotherapy
→ Please enter the regimen: Other: _____

☐ Yes ☐ No Is the patient experiencing severe toxicity requiring continuous monitoring (e.g. Grade 2-4 bullous dermatitis, transaminitis, pneumonitis, Stevens-Johnson syndrome, acute pancreatitis, primary adrenal insufficiency aseptic meningitis, encephalitis, transverse myelitis, myocarditis, pericarditis, arrhythmias, impaired ventricular function, conduction abnormalities)?

→ Please explain: _____

☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g. acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

→ Please explain: _____

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

→ Please explain: _____

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety infusion therapy AND the patient does not have access to a caregiver?

→ Please provide a description of the behavioral issue or impairment: _____

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition: ☐ Cardiovascular: _____
☐ Respiratory: _____
☐ Renal: _____
☐ Other: _____

☐ Yes ☐ No Is the patient within the initial 6 months of starting therapy?

→ How many continuous months of treatment has the patient received with the requested drug? _____

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.