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:
Please use Medicare Request Form

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., Opdivo (nivolumab), Keytruda (pembrolizumab), Bavencio (avelumab), or Imfinzi (durvalumab))?

☐ **Alveolar Soft Part Sarcoma (ASPS)**
Please indicate the clinical setting in which the requested medication will be used: ☐ Unresectable disease ☐ Metastatic disease ☐ Other
☐ Yes ☐ No Will the requested medication be used as a single agent?

☐ **Cervical Cancer**
☐ Yes ☐ No Is the requested medication being used to treat small cell neuroendocrine carcinoma of the cervix (NECC)?
☐ Yes ☐ No Will the requested medication be used in combination with etoposide and either cisplatin or carboplatin?
Please indicate the clinical setting in which the requested medication will be used: ☐ Persistent disease ☐ Recurrent disease ☐ Metastatic disease ☐ Other

☐ **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
☐ 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 (e.g., cisplatin, carboplatin)?

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Bladder urothelial carcinoma continued

Please identify the clinical setting in which the requested medication will be used:

☐ Stage II or Stage IIIA 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
☐ Stage IIIB disease
→ ☐ Yes ☐ No Will the requested drug be used as downstaging systemic therapy or flowing partial response or progression after primary treatment with concurrent chemoradiotherapy?

☐ **Hepatocellular carcinoma (HCC)**

Please indicate the clinical setting: ☐ Unresectable disease ☐ Metastatic disease ☐ Other
☐ Yes ☐ No Will the requested medication be used in combination with bevacizumab (Avastin)?
☐ 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
☐ 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)?

☐ **Mesothelioma**

Please indicate the type of mesothelioma the patient has:
☐ Malignant peritoneal mesothelioma ☐ Pericardial mesothelioma ☐ Tunica vaginalis testis mesothelioma ☐ Other
What is the place in therapy in which the requested medication will be used? ☐ First-line therapy ☐ Subsequent therapy
☐ Yes ☐ No Will the requested drug be used in combination with bevacizumab (Avastin)?

☐ **Non-small cell lung cancer (NSCLC)**

What is the clinical setting in which the requested drug will be used?

☐ **Stage II to IIIB disease**
→ ☐ Yes ☐ No ☐ Unknown Is the patient's tumor PD-L1 positive?
☐ Yes ☐ No Will the requested medication be used as a single agent?
☐ Yes ☐ No Will the requested medication be used as adjuvant therapy?

☐ **Recurrent disease** ☐ **Advanced disease** ☐ **Metastatic disease** ☐ **Other**
☐ Yes ☐ No ☐ Unknown Is the tumor negative for EGFR exon 19 deletions, L858R mutations, and ALK rearrangements?
→ ☐ Yes ☐ No Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?
☐ Yes ☐ No Will the requested medication be used as a single agent?
What is the place in therapy in which the requested medication will be used? ☐ Initial treatment ☐ Subsequent treatment

For tumor negative for EGFR exon 19 deletions, L858R mutations, and ALK rearrangements:

Please indicate the place in therapy:
☐ Continued maintenance therapy
☐ First-line therapy
→ ☐ Yes ☐ No ☐ Unknown Is the tumor PD-L1 expression positive (≥50%)?
☐ Subsequent therapy
☐ Other
What is the requested regimen? ☐ Single agent ☐ In combination with bevacizumab (Avastin) ☐ In combination with chemotherapy ☐ Other

☐ **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
Will the requested medication be used as first-line systemic or subsequent 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 (e.g., cisplatin, carboplatin)?

☐ **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?

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☐ **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 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 (e.g., cisplatin, carboplatin)?

☐ **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 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 (e.g., cisplatin, carboplatin)?

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., Opdivo (nivolumab), Keytruda (pembrolizumab), Bavencio (avelumab), or Imfinzi (durvalumab))?

☐ Yes ☐ No Is there evidence of disease progression or unacceptable toxicity while on the current regimen?

☐ 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)

☐ 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.