

**Tevimbra™ (tislelizumab-jsgr) 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**

**For Initial Authorization:**

1. Is diagnosis unresectable or metastatic disease? Yes \_\_\_ No \_\_\_
2. Please indicate the diagnosis and information:
  - Esophageal Squamous Cell Carcinoma (ESCC)**
    - a. Will tislelizumab-jsgr will be used after disease progression on prior systemic chemotherapy? Yes \_\_\_ No \_\_\_
      - i. Has member failed other programmed death 1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitors? Yes \_\_\_ No \_\_\_
      - ii. Will tislelizumab-jsgr be used as a single agent? Yes \_\_\_ No \_\_\_
    - b. Will tislelizumab-jsgr will be used as first-line treatment? Yes \_\_\_ No \_\_\_
      - i. Does tumor express PD-L1  $\geq 1\%$ ? Yes \_\_\_ No \_\_\_
      - ii. Will tislelizumab-jsgr be used in combination with platinum-containing chemotherapy? Yes \_\_\_ No \_\_\_
  - Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma**
    - a. Will tislelizumab-jsgr be used in the first-line setting in combination with platinum and fluoropyrimidine-based chemotherapy? Yes \_\_\_ No \_\_\_
    - b. Is disease human epidermal receptor 2 (HER2)-negative? Yes \_\_\_ No \_\_\_
    - c. Does tumor express programmed death ligand 1 (PD-L1)  $\geq 1\%$ ? Yes \_\_\_ No \_\_\_
  - Hepatocellular Carcinoma (HCC)**
    - a. Is disease liver-confined, unresectable, and member is ineligible for transplant? Yes \_\_\_ No \_\_\_
    - b. Is disease extrahepatic/metastatic and member is ineligible for resection, transplant, or locoregional therapy? Yes \_\_\_ No \_\_\_
    - c. Will tislelizumab-jsgr be used as first-line systemic therapy? Yes \_\_\_ No \_\_\_
    - d. Will tislelizumab-jsgr be used as a single agent? Yes \_\_\_ No \_\_\_

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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

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**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**Criteria**

**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_
2. Does member have any evidence of progressive disease while on tislelizumab-jsgr therapy? Yes \_\_\_ No \_\_\_
3. Has member experienced any adverse drug reactions related to tislelizumab-jsgr therapy? Yes \_\_\_ No \_\_\_  
*If yes, please specify adverse reactions:* \_\_\_\_\_

**Additional Information:** \_\_\_\_\_

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**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.*

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