OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

Tecentriq® (atezolizumab) & Tecentriq Hybreza® (atezolizumab/hyaluronidase-tqjs) 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 3—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:

☐ **Alveolar Soft Part Sarcoma (ASPS)**
- a. Is ASPS unresectable or metastatic? Yes☐ No☐
- b. For Tecentriq Hybreza, member's weight: _____(kg); Date taken: _____

☐ **Hepatocellular Carcinoma (HCC)**
- a. Is diagnosis advanced, unresectable, or 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☐

☐ **Small Cell Lung Cancer (SCLC)**
- a. Does member have extensive-stage disease? Yes☐ No☐
- b. Will atezolizumab be used as primary treatment in combination with carboplatin and etoposide? Yes☐ No☐
- c. Will atezolizumab be used as first-line maintenance treatment for disease that has not progressed on or after first-line induction therapy with atezolizumab or atezolizumab/hyaluronidase, carboplatin, and etoposide? Yes☐ No☐
  - i. Will maintenance treatment be given in combination with lurbinectedin? Yes☐ No☐

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.*

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Criteria

Page 2 of 3—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:

☐ **Muscle Invasive Bladder Cancer (MIBC)**

a. Will atezolizumab be used as adjuvant treatment after cystectomy? Yes☐ No☐
b. Is there presence of circulating tumor DNA molecular residual disease (ctDNA MRD) as determined by an FDA-authorized test? Yes☐ No☐
c. Will atezolizmab be used as a single agent? 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☐
c. Is diagnosis stage 2 or 3A NSCLC? Yes☐ No☐
   i. If yes, has member has undergone resection and completed platinum-based chemotherapy? Yes☐ No☐
   ii. Is PD-L1 expression ≥1% of tumor cells? Yes☐ No☐

☐ **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, please indicate the number of cycles:_____
d. Will atezolizumab be used in combination with paclitaxel (protein bound) and carboplatin? Yes☐ No☐

☐ **If diagnosis is not listed, please indicate diagnosis:**_____

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Page 3 of 3—Please complete and return all pages. Failure to complete all pages will result in processing delays.

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☐
   i. If yes, please specify adverse reactions: _____

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.

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