OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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 ≥1%? Yes☐ No☐

ii. Will tislelizumab-jsgr be used in combination with platinum-containing chemotherapy? Yes☐ No☐

☐ **Hepatocelluar 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☐

DRAFT

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

For Initial Authorization:

2. Please indicate the diagnosis and information: *(continued)*

☐ **Gastric or Gastroesophageal Junction (GEJ) or Esophageal Adenocarcinoma**

☐ Unresectable or metastatic gastric or 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) ≥1%? Yes☐ No☐

☐ Unresectable locally-advanced or metastatic gastric, GEJ, or esophageal adenocarcinoma

a. Will tislelizumab-jsgr be used in the first-line setting in combination with zanidatamab-hrii and fluoropyrimidine– and platinum-containing chemotherapy? Yes☐ No☐

b. Is disease HER2-positive immunohistochemistry (IHC) 3+ or IHC 2+/in situ hybridization (ISH)-positive? Yes☐ No☐

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: _____

_____

_____

_____

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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