SoonerCare
Oklahoma Health Care Authority

# State of Oklahoma
# Oklahoma Health Care Authority
# Tecentriq® (Atezolizumab) 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. Please indicate the diagnosis and information:
   - ❑ **Non-Small Cell Lung Cancer (NSCLC)**
     - A. Will atezolizumab be used for subsequent therapy for metastatic disease? Yes ☐ No ☐
     - B. Please indicate member's ECOG performance score: _____
     - C. Will atezolizumab be used as a single-agent? Yes ☐ No ☐
   - ❑ **Non-Squamous NSCLC**
     - A. Will atezolizumab be used as first-line therapy? Yes ☐ No ☐
     - B. Does member have EGFR or ALK mutations? Yes ☐ No ☐
     - C. Will atezolizumab be used in combination with bevacizumab, paclitaxel, and carboplatin? Yes ☐ No ☐
       - i. If "Yes" to the above question, please indicate the number of cycles: _____
   - ❑ **Urothelial Carcinoma**
     - A. Is diagnosis locally advanced or metastatic urothelial carcinoma? Yes ☐ No ☐
     - B. Did disease progress on or following platinum containing chemotherapy? Yes ☐ No ☐
     - C. Is member ineligible for cisplatin? Yes ☐ No ☐
   - ❑ **If answer is none of the above, please indicate diagnosis:** _____

**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 ☐

*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.*

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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