Prescriber Criteria Form

Tecentriq 2025 PA Fax 1374-A v2 010125.docx
Tecentriq (atezolizumab)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Tecentriq (atezolizumab).

Drug Name:
Tecentriq (atezolizumab)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of urothelial carcinoma? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of recurrent, advanced, or metastatic non-small cell lung cancer (NSCLC)? [If yes, then no further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of stage II to IIIB non-small cell lung cancer (NSCLC)? [If no, then skip to question 5.]	Yes ◯	No ◯
4	Will the requested drug be used as adjuvant treatment following resection and adjuvant chemotherapy? [No further questions.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of extensive-stage small cell lung cancer (ES-SCLC)? [If no, then skip to question 8.]	Yes ◯	No ◯
6	Will the requested drug be used in combination with etoposide and carboplatin? [If yes, then no further questions.]	Yes ◯	No ◯
7	Is requested drug being used as single agent maintenance following combination treatment with etoposide and carboplatin? [No further questions.]	Yes ◯	No ◯

8	Does the patient have a diagnosis of hepatocellular carcinoma? [If no, then skip to question 10.]	Yes ◯	No ◯
9	Will the requested drug be used as initial treatment in combination with bevacizumab? [No further questions.]	Yes ◯	No ◯
10	Does the patient have a diagnosis of melanoma? [If no, then skip to question 14.]	Yes ◯	No ◯
11	Does the patient have unresectable or metastatic disease? [If no, then no further questions.]	Yes ◯	No ◯
12	Does the patient have BRAF V600 mutation-positive disease? [If no, then no further questions.]	Yes ◯	No ◯
13	Will the requested drug be used in combination with cobimetinib and vemurafenib? [No further questions.]	Yes ◯	No ◯
14	Does the patient have a diagnosis of peritoneal mesothelioma, pericardial mesothelioma, or tunica vaginalis testis mesothelioma? [If no, then skip to question 16.]	Yes ◯	No ◯
15	Will the requested drug be used as subsequent therapy? [No further questions.]	Yes ◯	No ◯
16	Does the patient have a diagnosis of alveolar soft part sarcoma? [If yes, then no further questions.]	Yes ◯	No ◯
17	Does the patient have a diagnosis of persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix (NECC)?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____