

Prescriber Criteria Form

Tecentriq Hybreza 2025 PA Fax 6642-A v1 020125.docx  
 Tecentriq Hybreza (atezolizumab and hyaluronidase-tqjs)  
 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 Hybreza (atezolizumab and hyaluronidase-tqjs).

Drug Name:  
 Tecentriq Hybreza (atezolizumab and hyaluronidase-tqjs)

<b>Patient Name:</b>		
<b>Patient ID:</b>		
<b>Patient DOB:</b>	<b>Patient Phone:</b>	
<b>Prescriber Name:</b>		
<b>Prescriber Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Prescriber Phone:</b>	<b>Prescriber Fax:</b>	
<b>Diagnosis:</b>	<b>ICD Code(s):</b>	

<b>Please circle the appropriate answer for each question.</b>			
1	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
2	Does the patient have a diagnosis of stage II to IIIB non-small cell lung cancer (NSCLC)? [If no, then skip to question 4.]	Yes	No
3	Will the requested drug be used as adjuvant treatment following resection and adjuvant chemotherapy? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of extensive-stage small cell lung cancer (ES-SCLC)? [If no, then skip to question 6.]	Yes	No
5	Will the requested drug be used in combination with carboplatin and etoposide? [No further questions.]	Yes	No
6	Does the patient have a diagnosis of hepatocellular carcinoma? [If no, then skip to question 8.]	Yes	No
7	Will the requested drug be used as initial treatment in combination with bevacizumab? [No further questions.]	Yes	No

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

Comments:	
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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.

<b>Prescriber (or Authorized) Signature:</b> _____	<b>Date:</b> _____
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