Prescriber Criteria Form Tecentriq 2024 PA Fax 1374-A v3 010124.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 primary carcinoma of the urethra? [If no, then skip to question 5.]	Yes	No
2	Is the patient ineligible for platinum-containing chemotherapy? [If yes, then no further questions.]	Yes	No
3	Is the patient ineligible for cisplatin-containing chemotherapy? [If no, then no further questions.]	Yes	No
4	Does the patient's tumor express programmed death-ligand 1 (PD-L1)? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of recurrent, advanced, or metastatic non-small cell lung cancer (NSCLC)? [If no, then skip to question 9.]	Yes	No
6	Will the requested drug be used as subsequent therapy or continuation maintenance therapy? [If yes, then no further questions.]	Yes	No
7	Will the requested drug be used as first-line treatment of tumors with high programmed death-ligand 1 (PD-L1) expression (defined as PD-L1 stained greater than or equal to 50 percent of tumor cells or PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 10 percent of the tumor area) and no epidermal growth factor	Yes	No

	receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations? [If yes, then no further questions.]		
8	Will the requested drug be used in combination with carboplatin, paclitaxel, and bevacizumab, or in combination with carboplatin and albumin-bound paclitaxel for nonsquamous non-small cell lung cancer (NSCLC)? [No further questions.]	Yes	No
9	Does the patient have a diagnosis of stage II to IIIA non-small cell lung cancer (NSCLC)? [If no, then skip to question 11.]	Yes	No
10	Will the requested drug be used as adjuvant treatment following resection and adjuvant chemotherapy for tumors with programmed death-ligand (PD-L1) expression on greater than or equal to 1 percent of tumor cells? [No further questions.]	Yes	No
11	Does the patient have a diagnosis of small cell lung cancer? [If no, then skip to question 15.]	Yes	No
12	Does the patient have extensive-stage disease? [If no, then no further questions.]	Yes	No
13	Will the requested drug be used in combination with etoposide and carboplatin? [If yes, then no further questions.]	Yes	No
14	Is requested drug being used as single agent maintenance following combination treatment with etoposide and carboplatin? [No further questions.]	Yes	No
15	Does the patient have a diagnosis of hepatocellular carcinoma? [If no, then skip to question 17.]	Yes	No
16	Will the requested drug be used as initial treatment in combination with bevacizumab? [No further questions.]	Yes	No
17	Does the patient have a diagnosis of melanoma? [If no, then skip to question 21.]	Yes	No
18	Does the patient have unresectable or metastatic disease? [If no, then no further questions.]	Yes	No
19	Does the patient have BRAF V600 mutation-positive disease? [If no, then no further questions.]	Yes	No
20	Will the requested drug be used in combination with cobimetinib and vemurafenib? [No further questions.]	Yes	No
21	Does the patient have a diagnosis of peritoneal mesothelioma, pericardial mesothelioma, or tunica vaginalis testis mesothelioma? [If no, then skip to question 23.]	Yes	No

22	Will the requested drug be used as subsequent therapy? [No further questions.]	Yes	No
23	Does the patient have a diagnosis of unresectable or metastatic alveolar soft part sarcoma?	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:**_____