Tecentriq

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. What is the diagnosis?
   - ❑ Urothelial carcinoma – Bladder cancer
   - ❑ Urothelial carcinoma – Primary carcinoma of the urethra
   - ❑ Urothelial carcinoma – Upper genitourinary tract tumors or urothelial carcinoma of the prostate
   - ❑ Non-small cell lung cancer (NSCLC)
   - ❑ Small cell lung cancer
   - ❑ Hepatocellular carcinoma
   - ❑ Melanoma
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Has the patient experienced disease progression while on PD-1 or PD-L1 inhibitor therapy (e.g., Opdivo, Infinzi)? ❑ Yes ❑ No

4. Is the patient currently receiving therapy with the requested medication? ❑ Yes ❑ No *If No, skip to diagnosis section.*

5. Has the patient experienced disease progression or an unacceptable toxicity while receiving therapy with the requested medication? ❑ Yes ❑ No *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Urothelial Carcinoma – Bladder Cancer, Urothelial Carcinoma – Primary Carcinoma of the Urethra, Urothelial Carcinoma – Upper Genitourinary Tract Tumors or Urothelial Carcinoma of the Prostate

6. Will the requested medication be used as a single agent? ❑ Yes ❑ No

7. What is the place in therapy in which the requested medication will be used? ❑ First line therapy ❑ Other

8. What is the clinical setting in which the requested medication will be used?
   - ❑ Stage II or Stage IIIa disease
   - ❑ Locally advanced disease, *skip to #11*
   - ❑ Metastatic disease, *skip to #11*
   - ❑ Recurrent disease, *skip to #11*
   - ❑ Metastatic disease post-cystectomy, *skip to #11*
   - ❑ Local recurrence post-cystectomy, *skip to #11*
   - ❑ Stage IIIb disease, *skip to #10*
   - ❑ Muscle invasive local recurrence or persistent disease in a preserved bladder, *skip to #11*
   - ❑ Other _____

9. Was the patient's tumor present following reassessment of tumor status 2-3 months after primary treatment with concurrent chemotherapy? ❑ Yes ❑ No *If yes or no, skip to #11*

10. Will the requested drug be used as downstaging systemic therapy or following partial response or progression after primary treatment with concurrent chemoradiotherapy? ❑ Yes ❑ No

11. Is the patient eligible to receive cisplatin chemotherapy? ❑ Yes ❑ No

12. Does the patient's tumor express PD-L1 (defined as PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 5% of the tumor area)? ***ACTION REQUIRED: If Yes, please submit test results confirming PD-L1 tumor expression and no further questions.*** ❑ Yes ❑ No ❑ Unknown

13. Is the patient eligible to receive any platinum containing chemotherapy? ❑ Yes ❑ No

Section B: Non-Small Cell Lung Cancer (NSCLC)

14. Is the tumor negative for EGFR, ALK, and RET gene mutations? ***ACTION REQUIRED: Please attach documentation of EGFR, ALK or RET genomic aberration, where applicable.***
   - ❑ Yes, *skip to #18*
   - ❑ No, *skip to #16*
   - ❑ Unknown

15. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue? ❑ Yes ❑ No
    If yes or no, *skip to # 18*

16. Will the requested drug be used as a single agent? ❑ Yes ❑ No

17. What is the place in therapy in which the requested drug will be used? *Both answers skip to #23*
❑ Initial treatment ❑ Subsequent treatment

18. Will the requested drug be used in any of the following regimens?
❑ Single agent
❑ In combination with bevacizumab, carboplatin and paclitaxel or carboplatin and albumin-bound paclitaxel, *skip to #26*
❑ In combination with bevacizumab only, *skip to #31*
❑ Other

19. Will the requested drug be used as maintenance therapy? ❑ Yes ❑ No *If no, skip to #21*

20. Is there tumor response or stable disease following first-line monotherapy? ❑ Yes ❑ No *No further questions*

21. What is the place in therapy in which the requested drug will be used?
❑ First-line treatment ❑ Subsequent treatment, *skip to #23*
❑ adjuvant treatment following resection and platinum-based (e.g., cisplatin, oxaliplatin) chemotherapy, *skip to #24*

22. Does the patient's tumor express PD-L1 ≥50%? ***ACTION REQUIRED**: **If yes, please attach documentation of test results confirming PD-L1 ≥50%**.* ❑ Yes ❑ No ❑ Unknown

23. What is the clinical setting in which the requested drug will be used? *Any answer, no further questions*
❑ Recurrent disease ❑ Advanced disease ❑ Metastatic disease ❑ Other

24. What is the clinical setting in which the requested drug will be used? ❑ Stage II to IIIA disease ❑ Other

25. Does the patient's tumor express PD-L1 expression on ≥ 1% of tumor cells? ***ACTION REQUIRED: If yes, please attach documentation of test results confirming PD-L1 ≥ 1%.***
❑ Yes ❑ No ❑ Unknown *No Further Questions*

26. What is the patient's disease histology? ❑ Nonsquamous cell histology ❑ Squamous cell histology

27. What is the clinical setting in which the requested drug will be used?
❑ Recurrent disease ❑ Advanced disease
❑ Metastatic disease ❑ Other

28. What is the place in therapy in which the requested drug will be used?
❑ First-line treatment, *no further questions* ❑ Subsequent treatment

29. Is tumor ROS1 rearrangement positive? ***ACTION REQUIRED: Please attach documentation of ROS1 genomic aberration.*** ❑ Yes ❑ No ❑ Unknown *If no, no further questions*

30. Has the patient had a prior treatment with crizotinib, entrectinib, or ceritinib therapy?
❑ Yes ❑ No *No Further Questions*

31. Is there tumor response or stable disease following first-line atezolizumab, carboplatin, paclitaxel and bevacizumab regimen or atezolizumab, carboplatin, and albumin-bound paclitaxel regimen? ❑ Yes ❑ No

32. What is the patient's disease histology? ❑ Nonsquamous cell histology ❑ Squamous cell histology

33. Will the requested drug be used as maintenance therapy? ❑ Yes ❑ No

<u>Section D: Small Cell Lung Cancer</u>

34. Does the patient have extensive-stage disease? ❑ Yes ❑ No

35. Will the requested medication be used in combination with etoposide and carboplatin (followed by single agent maintenance)? ❑ Yes ❑ No

36. Will the requested medication be used for initial treatment? ❑ Yes ❑ No

Section E: Hepatocellular Carcinoma

37. What is the clinical setting in which the requested drug will be used?
    - ❑ Unresectable disease
    - ❑ Metastatic disease
    - ❑ Other

38. Will the requested medication be used for initial treatment? ❑ Yes ❑ No

39. Will the requested medication be used in combination with bevacizumab? ❑ Yes ❑ No

Section F: Melanoma

40. What is the clinical setting in which the requested medication will be used?
    - ❑ Unresectable disease
    - ❑ Metastatic disease
    - ❑ Other _____

41. Is the tumor positive for BRAF V600 mutation? ***ACTION REQUIRED: If Yes, please submit test results confirming BRAF V600 mutation.*** ❑ Yes ❑ No ❑ Unknown

42. Will the requested medication be used in combination with cobimetinib (Cotellic) and vemurafenib (Zelboraf)?
    ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720