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

Site of Service Questions (SOS):

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital
- ❑ Off Campus Outpatient Hospital
- ❑ Home infusion, *skip to Criteria Questions*
- ❑ Physician office, *skip to Criteria Questions*
- ❑ Ambulatory surgical, *skip to Criteria Questions*
- ❑ Pharmacy, *skip to Criteria Questions.*

B. Is this request to continue previously established treatment with the requested medication?
- ❑ No – This is a new therapy request (patient has not received 6 months or more of requested medication). *Skip to Clinical Criteria Questions*.
- ❑ Yes – This is a continuation of existing treatment (patient has received requested medication for 6 months). *Skip to Clinical Criteria Questions*.
- ❑ Yes – This is a continuation of an existing treatment (patient has received requested medication for 7 months or greater – initial 6 months plus 45 days grace period).

C. Is the patient receiving provider administered combination chemotherapy? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre- medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Has the patient experienced severe toxicity requiring continuous monitoring (e.g. Grade 2-4 bullous dermatitis, transaminitis, pneumonitis, Stevens-Johnson syndrome, acute pancreatitis, primary adrenal insufficiency aseptic meningitis, encephalitis, transverse myelitis, myocarditis, pericarditis, arrhythmias, impaired ventricular function, or conduction abnormalities)? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation***.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Does the patient have severe venous access issues that require the use of a special intervention only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation. ❑ Yes ❑ No

Criteria Questions:

What is the ICD-10 code? _____

1.What is the diagnosis?

❒ Urothelial carcinoma – Bladder cancer, *Continue to #2*

❒ Urothelial carcinoma – Primary carcinoma of the urethra, *Continue to #2*

❒ Urothelial carcinoma – Upper genitourinary tract tumors or urothelial carcinoma of the prostate, *Continue to #2*

❒ Non-small cell lung cancer (NSCLC), *Continue to #2*

❒ Small cell lung cancer (SCLC), *Continue to #2*

❒ Hepatocellular carcinoma (HCC), *Continue to #2*

❒ Melanoma, *Continue to #2*

❒ Mesothelioma (malignant peritoneal mesothelioma, pericardial mesothelioma, or tunica vaginalis testis mesothelioma), *Continue to #2*

❒ Alveolar soft part sarcoma (ASPS), *Continue to #2*

❒ Cervical Cancer, *Continue to #2*

❒ Other, *Continue to #2*

2. Has the patient experienced disease progression while on PD-1 or PD-L1 inhibitor therapy (e.g., Opdivo, Imfinzi)?

❒ Yes, *Continue to #3*

❒ No, *Continue to #3*

3. Is the patient currently receiving therapy with the requested medication?

❒ Yes, *Continue to #4*

❒ No, *Continue to #16*

Continuation of Therapy

4. Is this request for adjuvant treatment of non-small cell lung cancer (NSCLC)?

❒ Yes, *Continue to #5*

❒ No, *Continue to #7*

5. Is there evidence of disease progression or unacceptable toxicity while on the current regimen?

❒ Yes, *Continue to #6*

❒ No, *Continue to #6*

6. How many continuous months of treatment has the patient received with the requested medication?

_____ months, *No Further Questions*

7. Is there evidence of disease progression or unacceptable toxicity while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Initiation Therapy

16. What is the diagnosis?

❒ Urothelial carcinoma – Bladder cancer, *Continue to #17*

❒ Urothelial carcinoma – Primary carcinoma of the Urethra, *Continue to #30*

❒ Urothelial carcinoma – Upper genitourinary tract tumors or urothelial carcinoma of the prostate, *Continue to #50*

❒ Non-small cell lung cancer (NSCLC), *Continue to #70*
❒ Small cell lung cancer (SCLC), *Continue to #100*
❒ Hepatocellular carcinoma (HCC), *Continue to #150*
❒ Melanoma, *Continue to #160*
❒ Malignant Peritoneal Mesothelioma, *Continue to #165*
❒ Pericardial Mesothelioma, *Continue to #165*
❒ Tunica Vaginalis Testis Mesothelioma, *Continue to #165*
❒ Alveolar soft part sarcoma (ASPS), *Continue to #170*
❒ Cervical Cancer, *Continue to #175*

Urothelial carcinoma – Bladder cancer

17. Will the requested medication be used as a single agent?
❒ Yes, *Continue to #18*
❒ No, *Continue to #18*

18. What is the place in therapy in which the requested medication will be used?
❒ First line therapy, *Continue to #21*
❒ Subsequent therapy, *Continue to #21*

First line therapy

21. What is the clinical setting in which the requested medication will be used?
❒ Stage II or stage IIIa disease, *Continue to #22*
❒ Locally advanced disease, *Continue to #24*
❒ Metastatic disease, *Continue to #24*
❒ Metastatic disease post-cystectomy, *Continue to #24*
❒ Local recurrence post-cystectomy, *Continue to #24*
❒ Muscle invasive local recurrence or persistent disease in a preserved bladder, *Continue to #24*
❒ Stage IIIb disease, *Continue to #23*
❒ Other, *No Further Questions*

22. Was the patient's tumor present following reassessment of tumor status 2-3 months after primary treatment with either concurrent chemoradiotherapy, radiotherapy alone, or transurethral resection of bladder tumor (TURBT)?
❒ Yes, *Continue to #24*
❒ No, *Continue to #24*

23. Will the requested medication be used as downstaging systemic therapy or following partial response or progression after primary treatment with concurrent chemoradiotherapy?
❒ Yes, *Continue to #24*
❒ No, *Continue to #24*

❒ 24.Is the patient eligible to receive cisplatin chemotherapy?
❒ Yes, *Continue to #25*
❒ No, *Continue to #25*

25. 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 attach chart note(s) or test results confirming PD-L1 tumor expression*

❒ Yes, *No Further Questions*

❒ No, *Continue to #26*

❒ Unknown, *Continue to #26*

26. Is the patient eligible to receive any platinum containing chemotherapy (e.g., cisplatin, carboplatin)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Urothelial carcinoma – Primary carcinoma of the Urethra

30. Will the requested medication be used as a single agent?

❒ Yes, *Continue to #31*

❒ No, *Continue to #31*

31. What is the place in therapy in which the requested medication will be used?

❒ First line therapy, *Continue to #35*

❒ Subsequent therapy, *Continue to #35*

35. What is the clinical setting in which the requested medication will be used?

❒ Locally advanced disease, *Continue to #36*

❒ Metastatic disease, *Continue to #36*

❒ Recurrent disease, *Continue to #36*

❒ Other, *Continue to #36*

36. Is the patient eligible to receive cisplatin chemotherapy?

❒ Yes, *Continue to #37*

❒ No, *Continue to #37*

37. 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 attach chart note(s) or test results confirming PD-L1 tumor expression*

❒ Yes, *No Further Questions*

❒ No, *Continue to #38*

❒ Unknown, *Continue to #38*

38. Is the patient eligible to receive any platinum containing chemotherapy (e.g., cisplatin, carboplatin)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Urothelial carcinoma – Upper genitourinary tract tumors or Urothelial carcinoma of the prostate

50. Will the requested medication be used as a single agent?

❒ Yes, *Continue to #51*

❒ No, *Continue to #51*

51.What is the place in therapy in which the requested medication will be used?

❒ First line therapy, *Continue to #55*

❒ Subsequent therapy, *Continue to #55*

55. What is the clinical setting in which the requested medication will be used?

❒ Locally advanced disease, *Continue to #56*

❒ Metastatic disease, *Continue to #56*

❒ Other, *Continue to #56*

56. Is the patient eligible to receive cisplatin chemotherapy?

❒ Yes, *Continue to #57*

❒ No, *Continue to #57*

57. 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 attach chart note(s) or test results confirming PD-L1 tumor expression*

❒ Yes, *No Further Questions*

❒ No, *Continue to #58*

❒ Unknown, *Continue to #58*

58. Is the patient eligible to receive any platinum containing chemotherapy (e.g., cisplatin, carboplatin)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Non-small cell lung cancer (NSCLC)

70. What is the clinical setting in which the requested medication will be used?

❒ Recurrent disease, *Continue to #71*

❒ Advanced disease, *Continue to #71*

❒ Metastatic disease, *Continue to #71*

❒ Stage II to IIIB disease, *Continue to #80*

❒ Other, *No Further Questions*

71. Is the tumor negative for EGFR exon 19 deletions, L858R mutations, and ALK rearrangements? ***ACTION REQUIRED****: If Yes, please attach chart note(s) or test results of EGFR exon 19 deletions, L858R mutations, and ALK rearrangements*

❒ Yes, *Continue to #75*

❒ No, *Continue to #73*

❒ Unknown, *Continue to #72*

72. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?

❒ Yes, *Continue to #75*

❒ No, *Continue to #73*

73. Will the requested medication be used as a single agent?

❒ Yes, *Continue to #74*

❒ No, *Continue to #74*

74. What is the place in therapy in which the requested medication will be used?

❒ Initial treatment, *No Further Questions*

❒ Subsequent treatment, *No Further Questions*

75. What is the place in therapy in which the requested medication will be used?

❒ *Continued maintenance therapy, Continue to #76*

❒ First-line therapy, *Continue to #77*

❒ Subsequent therapy, *Continue to #79*

❒ Other, *No Further Questions*

76. What is the requested regimen?

❒ Single agent, *No Further Questions*

❒ In combination with bevacizumab (Avastin), *No Further Questions*

❒ Other, *No Further Questions*

77. What is the requested regimen?

❒ Single agent, *Continue to #78*

❒ In combination with chemotherapy, *No Further Questions*

❒ Other, *Continue to #78*

78. Is the tumor PD-L1 expression positive (≥50%)? ***ACTION REQUIRED****: If yes, please attach chart note(s) or test results confirming PD-L1 positive status*

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

❒ Unknown, *No Further Questions*

79. What is the requested regimen?

❒ Single agent, *No Further Questions*

❒ In combination with chemotherapy, *No Further Questions*

❒ Other, *No Further Questions*

80. Is the patient's tumor PD-L1 positive? ***ACTION REQUIRED****: If yes, please attach chart note(s) or test results confirming PD-L1 positive status*

❒ Yes, *Continue to #81*

❒ No, *Continue to #81*

❒ Unknown, *Continue to #81*

81. Will the requested medication be used as a single agent?

❒ Yes, *Continue to #82*

❒ No, *Continue to #82*

82. Will the requested medication be used as adjuvant therapy?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Small cell lung cancer (SCLC)

100. Does the patient have extensive-stage disease?

❒ Yes, *Continue to #101*

❒ No, *Continue to #101*

101. Will the requested medication be used in combination with etoposide and carboplatin (followed by single agent maintenance)?

❒ Yes, *Continue to #102*

❒ No, *Continue to #102*

102. Will the requested medication be used for initial treatment?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Hepatocellular carcinoma

150. What is the clinical setting in which the requested medication will be used?

❒ Unresectable disease, *Continue to #151*

❒ Metastatic disease, *Continue to #151*

❒ Other, *Continue to #151*

151. Will the requested medication be used for initial treatment?

❒ Yes, *Continue to #152*

❒ No, *Continue to #152*

152. Will the requested medication be used in combination with bevacizumab (Avastin)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Melanoma

160. What is the clinical setting in which the requested medication will be used?

❒ Unresectable disease, *Continue to #161*

❒ Metastatic disease, *Continue to #161*

❒ Other, *Continue to #161*

161. Is the tumor positive for BRAF V600 mutation? ***ACTION REQUIRED****: If yes, please attach chart note(s) or test results confirming BRAF V600 mutation*

❒ Yes, *Continue to #162*

❒ No, *Continue to #162*

❒ Unknown, *Continue to #162*

162. Will the requested medication be used in combination with cobimetinib (Cotellic) and vemurafenib (Zelboraf)?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Malignant peritoneal mesothelioma

Pericardial mesothelioma

Tunica vaginalis testis mesothelioma

165. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *Continue to #166*

❒ Subsequent treatment, *Continue to #166*

166. Will the requested medication be used in combination with bevacizumab (Avastin)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Alveolar Soft Part Sarcoma (ASPS)

170. What is the clinical setting in which the requested medication will be used?
❒ Unresectable disease, *Continue to #171*
❒ Metastatic disease, *Continue to #171*
❒ Other, *Continue to #171*

171. Will the requested medication be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Cervical Cancer

175. Is the requested medication being used to treat small cell neuroendocrine carcinoma of the cervix (NECC)?
❒ Yes, *Continue to #176*
❒ No, *Continue to #176*

176. Will the requested medication be used in combination with etoposide and either cisplatin or carboplatin?
❒ Yes, *Continue to #177*
❒ No, *Continue to #177*

177. What is the clinical setting in which the requested medication will be used?
❒ Persistent disease, *No Further Questions*
❒ Recurrent disease, *No Further Questions*
❒ Metastatic disease, *No Further Questions*
❒ Other, *No Further Questions*

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