Tecentriq

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

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 (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

What is the ICD-10 code? _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org

Criteria Questions:

1. What is the diagnosis?

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

❒ Cervical Cancer, *Continue to 2*

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

❒ Melanoma, *Continue to 2*

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

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

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

❒ Other, please specify. _____, *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 8*

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*

8. What is the diagnosis?

❒ Alveolar soft part sarcoma (ASPS), *Continue to 33*

❒ Cervical Cancer, *Continue to 35*

❒ Hepatocellular carcinoma (HCC), *Continue to 25*

❒ Melanoma, *Continue to 28*

❒ Non-small cell lung cancer (NSCLC), *Continue to 9*

❒ Pericardial Mesothelioma, *Continue to 31*

❒ Peritoneal Mesothelioma, *Continue to 31*

❒ Small cell lung cancer (SCLC), *Continue to 22*

❒ Tunica Vaginalis Testis Mesothelioma, *Continue to 31*

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

❒ Advanced disease, *Continue to 10*

❒ Metastatic disease, *Continue to 10*

❒ Recurrent disease, *Continue to 10*

❒ Other, please specify, _____, *Continue to 10*

10. 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 ***ACTION REQUIRED****: Submit supporting documentation, Continue to 14*

❒ No, *Continue to 12*

❒ Unknown, *Continue to 11*

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

❒ Yes, *Continue to 14*

❒ No, *Continue to 12*

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

❒ Yes, *Continue to 13*

❒ No, *Continue to 13*

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

❒ Initial treatment, *No further questions*

❒ Subsequent treatment, *No further questions*

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

❒ Adjuvant therapy, *Continue to 19*

❒ *Continued maintenance therapy, Continue to 15*

❒ First-line therapy, *Continue to 16*

❒ Subsequent therapy, *Continue to 18*

❒ Other, please specify. _____, *No further questions*

15. What is the requested regimen?

❒ Single agent, *No further questions*

❒ In combination with bevacizumab, *No further questions*

❒ Other, please specify. _____, *No further questions*

16. What is the requested regimen?

❒ Single agent, *Continue to 17*

❒ In combination with chemotherapy with or without bevacizumab, *No further questions*

❒ Other, please specify. _____, *No further questions*

17. Is the tumor PD-L1 expression positive (greater than or equal to 50%)? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or test results confirming PD-L1 positive status.

❒ Yes ***ACTION REQUIRED***: *Submit supporting documentation, No further questions*

❒ No, *No further questions*

❒ Unknown, *No further questions*

18. What is the requested regimen?

❒ Single agent, *No further questions*

❒ In combination with chemotherapy, *No further questions*

❒ Other, please specify. _____, *No further questions*

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

❒ Stage II to III disease, *Continue to 20*

❒ Other, please specify. _____, *Continue to 20*

20. 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 ***ACTION REQUIRED***: *Submit supporting documentation, Continue to 21*

❒ No, *Continue to 21*

❒ Unknown, *Continue to 21*

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

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

22. Does the patient have extensive-stage disease?

❒ Yes, *Continue to 23*

❒ No, *Continue to 23*

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

❒ Yes, *Continue to 24*

❒ No, *Continue to 24*

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

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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

❒ Disease with extensive liver tumor burden, *Continue to 26*

❒ Inoperable disease, *Continue to 26*

❒ Metastatic disease, *Continue to 26*

❒ Unresectable disease, *Continue to 26*

❒ Other, please specify. _____, *Continue to 26*

26. Will the requested medication be used for initial treatment?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

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

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

❒ Metastatic disease, *Continue to 29*

❒ Unresectable disease, *Continue to 29*

❒ Other, please specify. _____, *Continue to 29*

29. 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 ***ACTION REQUIRED****: Submit supporting documentation, Continue to 30*

❒ No, *Continue to 30*

❒ Unknown, *Continue to 30*

30. Will the requested medication be used in combination with cobimetinib (Cotellic) and vemurafenib (Zelboraf)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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

❒ First-line treatment, *Continue to 32*

❒ Subsequent treatment, *Continue to 32*

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

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

❒ Metastatic disease, *Continue to 34*

❒ Unresectable disease, *Continue to 34*

❒ Other, please specify. _____, *Continue to 34*

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

35. Is the requested medication being used to treat small cell neuroendocrine carcinoma of the cervix (NECC)?
❒ Yes, *Continue to 36*
❒ No, *Continue to 36*

36. Will the requested medication be used in combination with etoposide and either cisplatin or carboplatin?
❒ Yes, *Continue to 37*
❒ No, *Continue to 37*

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

❒ Metastatic disease, *No further questions*

❒ Persistent disease, *No further questions*

❒ Recurrent disease, *No further questions*

❒ Other, please specify. _____, *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 Priority Partners.

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

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