

**Tecentriq® (atezolizumab) & Tecentriq Hybreza® (atezolizumab/hyaluronidase-tqjs)**  
**Prior Authorization Form**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Drug Information**

Physician Billing (HCPCS code): \_\_\_\_\_ ) Start Date (or date of next dose): \_\_\_\_\_

Dose: \_\_\_\_\_ Regimen: \_\_\_\_\_

**Billing Provider Information**

Provider NPI: \_\_\_\_\_ Provider Name: \_\_\_\_\_

Provider Phone: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

**Prescriber Information**

Prescriber NPI: \_\_\_\_\_ Prescriber Name: \_\_\_\_\_

Prescriber Phone: \_\_\_\_\_ Prescriber Fax: \_\_\_\_\_ Specialty: \_\_\_\_\_

**Criteria**

**\*Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.\***  
**For Initial Authorization:**

1. Please indicate the diagnosis and information:

**Non-Squamous Non-Small Cell Lung Cancer (NSCLC)**

- A. Will atezolizumab be used as first-line therapy for metastatic disease? Yes \_\_\_ No \_\_\_
- B. Does member have epidermal growth factor receptor (EGFR), anaplastic lymphoma kinase (ALK), ROS1, BRAF, MET exon 14 skipping, or RET mutations? Yes \_\_\_ No \_\_\_
- C. Will atezolizumab be used in combination with bevacizumab, paclitaxel, and carboplatin?  
Yes \_\_\_ No \_\_\_
  - i. If yes to the above question, please indicate the number of cycles: \_\_\_\_\_
- D. Will atezolizumab be used in combination with paclitaxel (protein bound) and carboplatin?  
Yes \_\_\_ No \_\_\_

**Non-Small Cell Lung Cancer (NSCLC)**

- A. Will atezolizumab be used as first-line therapy for metastatic disease? Yes \_\_\_ No \_\_\_
  - i. If yes, will atezolizumab be used as a single-agent? Yes \_\_\_ No \_\_\_
  - ii. If yes, does member have EGFR, ALK, ROS1, BRAF, MET exon 14 skipping, or RET mutations?  
Yes \_\_\_ No \_\_\_
  - iii. If yes, does disease have high programmed death ligand-1 (PD-L1) expression determined by the following [check applicable box(es)]?
    - PD-L1 stained >50% of tumor cells (TC>50%)
    - PD-L1 stained tumor-infiltrating immune cells (IC) covering >10% of the tumor area (IC>10%)
- B. Will atezolizumab be used for subsequent therapy for metastatic disease? Yes \_\_\_ No \_\_\_
  - i. If yes, will atezolizumab be used as a single-agent? Yes \_\_\_ No \_\_\_
- C. Is diagnosis stage 2 or 3A NSCLC? Yes \_\_\_ No \_\_\_
  - i. If yes, has member has undergone resection and completed platinum-based chemotherapy?  
Yes \_\_\_ No \_\_\_
  - ii. Is PD-L1 expression  $\geq 1\%$  of tumor cells? Yes \_\_\_ No \_\_\_

(Page 1 of 2)

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization Unit

Fax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE

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Prior Authorization Form**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Criteria**

\*Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.\*

**For Initial Authorization, continued::**

1. Please indicate the diagnosis and information, continued:

**Small Cell Lung Cancer (SCLC)**

- A. Will atezolizumab be used as first-line therapy? Yes \_\_\_\_\_ No \_\_\_\_\_
- B. Does member have extensive-stage disease? Yes \_\_\_\_\_ No \_\_\_\_\_
- C. Will atezolizumab be used in combination with carboplatin and etoposide? Yes \_\_\_\_\_ No \_\_\_\_\_

**Hepatocellular Carcinoma (HCC)**

- A. Is diagnosis advanced, unresectable, or metastatic HCC? Yes \_\_\_\_\_ No \_\_\_\_\_
- B. Will atezolizumab be used in combination with bevacizumab? Yes \_\_\_\_\_ No \_\_\_\_\_
- C. Has member received prior systemic therapy? Yes \_\_\_\_\_ No \_\_\_\_\_

**Melanoma**

- A. Is diagnosis unresectable or metastatic melanoma? Yes \_\_\_\_\_ No \_\_\_\_\_
- B. Is disease BRAF V600 mutation-positive? Yes \_\_\_\_\_ No \_\_\_\_\_
- C. Will atezolizumab be used in combination with cobimetinib and vemurafenib? Yes \_\_\_\_\_ No \_\_\_\_\_

**Alveolar Soft Part Sarcoma (ASPS)**

- A. Is ASPS unresectable or metastatic? Yes \_\_\_\_\_ No \_\_\_\_\_

**If diagnosis is not listed, please indicate diagnosis:** \_\_\_\_\_

Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For Continued Authorization:**

1. Date of last dose: \_\_\_\_\_
2. Does member have any evidence of progressive disease while on atezolizumab? Yes \_\_\_\_\_ No \_\_\_\_\_
  - i. If "No" to the above question, was atezolizumab used in combination with bevacizumab, paclitaxel, and carboplatin for non-squamous NSCLC? Yes \_\_\_\_\_ No \_\_\_\_\_
  - ii. If used in combination with bevacizumab, paclitaxel, and carboplatin for non-squamous NSCLC, how many cycles has the member received? \_\_\_\_\_
  - iii. Will atezolizumab be used in combination with bevacizumab for continued treatment? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Has the member experienced adverse drug reactions related to atezolizumab therapy? Yes \_\_\_\_\_ No \_\_\_\_\_
  - i. If yes, please specify adverse reactions: \_\_\_\_\_

Additional information: \_\_\_\_\_  
\_\_\_\_\_

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.*

*Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

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