Tecentriq® (atezolizumab) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Oncologist** ☐ **Hematologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
Address: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Tecentriq (atezolizumab) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Has the patient experienced disease progression while receiving another programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor (e.g., Opdivo (nivolumab), Keytruda (pembrolizumab), Bavencio (avelumab), or Imfinzi (durvalumab))?

☐ **Alveolar Soft Part Sarcoma (ASPS)**
Please indicate the clinical setting in which the requested medication will be used: ☐ Unresectable disease ☐ Metastatic disease ☐ Other
☐ Yes ☐ No Will the requested medication be used as a single agent?

☐ **Cervical Cancer**
☐ Yes ☐ No Is the requested medication being used to treat small cell neuroendocrine carcinoma of the cervix (NECC)?
☐ Yes ☐ No Will the requested medication be used in combination with etoposide and either cisplatin or carboplatin?
Please indicate the clinical setting in which the requested medication will be used: ☐ Persistent disease ☐ Recurrent disease ☐ Metastatic disease ☐ Other

☐ **Hepatocellular carcinoma (HCC)**
Please indicate the clinical setting: ☐ Unresectable disease ☐ Inoperable disease ☐ Metastatic disease ☐ Disease with extensive liver tumor burden ☐ Other
☐ Yes ☐ No Will the requested medication be used in combination with bevacizumab (Avastin)?
☐ Yes ☐ No Will the requested medication be used for initial treatment?

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☐ **Melanoma**
Please indicate the clinical setting in which the requested medication will be used: ☐ Unresectable disease ☐ Metastatic disease ☐ Other
☐ Yes ☐ No ☐ Unknown Is the tumor positive for BRAF V600 mutation?
☐ Yes ☐ No Will the requested medication be used in combination with cobimetinib (Cotellic) and vemurafenib (Zelboraf)?

☐ **Mesothelioma**
Please indicate the type of mesothelioma the patient has:
☐ Peritoneal mesothelioma ☐ Pericardial mesothelioma ☐ Tunica vaginalis testis mesothelioma ☐ Other
What is the place in therapy in which the requested medication will be used? ☐ First-line therapy ☐ Subsequent therapy
☐ Yes ☐ No Will the requested drug be used in combination with bevacizumab (Avastin)?

☐ **Non-small cell lung cancer (NSCLC)**
What is the clinical setting in which the requested drug will be used?
☐ Recurrent disease ☐ Advanced disease ☐ Metastatic disease ☐ Other
☐ Yes ☐ No ☐ Unknown Is the tumor negative for EGFR exon 19 deletions, L858R mutations, and ALK rearrangements?
→ ☐ Yes ☐ No Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?
☐ Yes ☐ No Will the requested medication be used as a single agent?
What is the place in therapy in which the requested medication will be used? ☐ Initial treatment ☐ Subsequent treatment

For tumor negative for EGFR exon 19 deletions, L858R mutations, and ALK rearrangements:
What is the requested regimen? ☐ Single agent ☐ In combination with bevacizumab ☐ In combination with chemotherapy with or without bevacizumab ☐ Other
Please indicate the place in therapy:
☐ Adjuvant therapy
→ Please indicate the clinical setting in which the requested medication will be used: ☐ Stage II to III disease ☐ Other
☐ Yes ☐ No ☐ Unknown Is the patient's tumor PD-L1 positive?
☐ Continued maintenance therapy
☐ First-line therapy
→ ☐ Yes ☐ No ☐ Unknown Is the tumor PD-L1 expression positive (≥50%)?
☐ Subsequent therapy
☐ Other

☐ **Small cell lung cancer (small cell carcinoma)**
☐ Yes ☐ No Does the patient have extensive-stage disease?
☐ Yes ☐ No Will the requested medication be used in combination with etoposide and carboplatin (followed by single agent maintenance)?
☐ Yes ☐ No Will the requested medication be used for initial treatment?

For Continuation Requests (clinical documentation required for all requests):
☐ Yes ☐ No Has the patient experienced disease progression while receiving another programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor (e.g., Opdivo (nivolumab), Keytruda (pembrolizumab), Bavencio (avelumab), or Imfinzi (durvalumab))?
☐ Yes ☐ No Is there evidence of disease progression or unacceptable toxicity while on the current regimen?
☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Is the patient continuing on a maintenance regimen that includes provider administered combination chemotherapy including but not limited to the following?
→ ☐ The requested medication will be used in combination with bevacizumab for non-small cell lung cancer (NSCLC)
☐ Another combination chemotherapy
→ Please enter the regimen: Other: _____

☐ Yes ☐ No Is the patient experiencing 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, conduction abnormalities)?
→ Please explain: _____

☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?
→ Please explain: _____

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
→ Please explain: _____

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety infusion therapy AND the patient does not have access to a caregiver?
→ Please provide a description of the behavioral issue or impairment: _____

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☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the patient's ability to tolerate a large volume or load or predispose the patient to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition:
- ☐ Cardiovascular: _____
- ☐ Respiratory: _____
- ☐ Renal: _____
- ☐ Other: _____

☐ Yes ☐ No Is the patient within the initial 6 months of starting therapy?

→ How many continuous months of treatment has the patient received with the requested drug? _____

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.