Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Tecentriq
(atezolizumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Tecentriq 840mg/14ml vial ☐ Tecentriq 1200mg/20ml vial ICD10:

Dose: Frequency of therapy: Duration of therapy:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? Yes ☐ No ☐

What is your patient's diagnosis?
☐ Alveolar soft part sarcoma (ASPS)
☐ hepatocellular carcinoma (HCC)
☐ Non-small cell lung cancer
☐ small cell lung cancer (SCLC)
☐ urothelial cell carcinoma (UCC, also transitional cell carcinoma, TCC)
☐ melanoma
☐ other *(please specify):*

Clinical Information

(if melanoma) Does your patient have BRAF V600 mutation-positive disease? Yes ☐ No ☐
(if melanoma) Does your patient have unresectable or metastatic disease? Yes ☐ No ☐
(if melanoma) Will the drug requested be taken in combination with cobimetinib (Cotellic) and vemurafenib (Zelboraf)? Yes ☐ No ☐

(if ASPS or HCC) Does your patient have unresectable or metastatic disease? Yes ☐ No ☐

(if HCC) Has your patient received systemic therapy for this diagnosis before requesting this medication? Yes ☐ No ☐
(if HCC) Is/Will the requested medication (be)ing used in combination with bevacizumab (Alymsys, Avastin, Mvasi, Zirabev)? Yes ☐ No ☐
(if SCLC) Does your patient have extensive stage (Stage 4) disease (ES-SCLC)? Yes ☐ No ☐
(if SCLC) Will/Was this medication (be) used in combination with carboplatin and etoposide (Etopophos or Toposar)? Yes ☐ No ☐
(if SCLC) Is this medication being used as part of first line therapy? Yes ☐ No ☐

(if NSCLC) Is this medication being used as adjuvant treatment (that is treatment given after the main treatment to reduce the chance of cancer coming back by destroying any remaining cancer cells)? Yes ☐ No ☐

(if adjuvant treatment of NSCLC) Does the patient have stage II (2) (including IIA or IIB) or stage IIIA (3A) disease? Yes ☐ No ☐

(if adjuvant treatment of NSCLC) Does the patient have PD-L1 expression on 1% or more of the tumor cells? Yes ☐ No ☐

(if adjuvant treatment of NSCLC) Is this medication being requested AFTER resection of the tumor and platinum-based chemotherapy (such as carboplatin, cisplatin)? Yes ☐ No ☐

(if not adjuvant treatment for NSCLC) Does your patient have metastatic disease? Yes ☐ No ☐

(if UCC) Does your patient have locally advanced, recurrent or metastatic disease? Yes ☐ No ☐
(if UCC) Is your patient ineligible for treatment with cisplatin? Yes ☐ No ☐

(if metastatic NSCLC) Does your patient have one of the following gene mutations?
☐ EGFR (epidermal growth factor)-positive
☐ ALK (anaplastic lymphoma kinase)-positive
☐ Testing did not indicate either EGFR mutation- or ALK-positive disease
☐ Molecular testing was not done

(if EGFR-positive) Did your patient have disease progression while on either Tarceva, Gilotrif, Iressa, Tagrisso, or Portrazza? Yes ☐ No ☐

(if ALK-positive) Did your patient have disease progression while on either Xalkori, Zykadia, or Alecensa? Yes ☐ No ☐

(if metastatic NSCLC) Has your patient previously received a systemic immune checkpoint inhibitor (such as Keytruda, Opdivo)? Yes ☐ No ☐
(if metastatic NSCLC OR UCC and not ineligible for cisplatin) Did your patient have disease progression after treatment with platinum-based chemotherapy (i.e. like carboplatin, cisplatin)? Yes ☐ No ☐
(if no EGFR or ALK mutation) Is this medication the first treatment your patient has received for this diagnosis? Yes ☐ No ☐
(if no EGFR or ALK mutation) Is/Will this medication be(ing) used in combination with Avastin, paclitaxel, and carboplatin? Yes ☐ No ☐
(if not in combo with bevacizumab, paclitaxel, and carboplatin) Is/Will this medication be(ing) used in combination with paclitaxel protein-bound (Abraxane) and carboplatin? Yes ☐ No ☐
(if not in combo with paclitaxel protein-bound and carboplatin) Does your patient's tumors have high PD-L1 expression (PD-L1 stained greater than or equal to 50% of tumor cells [TC ≥ 50%] or PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 10% of the tumor area [IC ≥ 10%)? Yes ☐ No ☐

For Non-small cell lung cancer ONLY:

Does the patient have advanced or metastatic squamous or non-squamous cell disease? Yes ☐ No ☐

Is this medication being used as monotherapy (single-agent therapy)? Yes ☐ No ☐

(if YES to both questions above) Is the patient currently receiving this medication already? Yes ☐ No ☐

(if no) Is this medication being used for first-line therapy or subsequent therapy?
☐ First-line therapy
☐ Subsequent therapy

Does the patient have a performance status of 3? Yes ☐ No ☐

(if initial therapy) Do your patient's tumors have either of the following: 1) PD-L1 greater than or equal to 50% of tumor cells (tumor proportion score [TPS] greater than or equal to 50%) or 2) PD-L1 stained tumor-infiltrating immune cells covering greater than or equal to 10% of the tumor area (IC greater than or equal to 10%)? Yes ☐ No ☐

(if subsequent therapy) Does the patient have a programmed death-ligand 1 (PD-L1) stained less than 1% of tumor cells (tumor proportion score [TPS] less than 1%)? Yes ☐ No ☐

The covered alternative is Keytruda (pembrolizumab). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient has had a trial of the alternative.
☐ The patient tried the alternative, but they had a significant intolerance to it.
☐ The patient cannot try the alternative because of a contraindication to this medication.
☐ Other

Additional pertinent information *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ Date:_____

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