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

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. What is the diagnosis?
   - ❑ Urothelial carcinoma – Bladder cancer
   - ❑ Urothelial carcinoma – Primary carcinoma of the urethra
   - ❑ Urothelial carcinoma – Upper genitourinary tract tumors or urothelial carcinoma of the prostate
   - ❑ Non-small cell lung cancer (NSCLC)
   - ❑ Breast cancer
   - ❑ Small cell lung cancer
   - ❑ Hepatocellular carcinoma
   - ❑ Melanoma
   - ❑ Mesothelioma (malignant peritoneal mesothelioma, pericardial mesothelioma, or tunica vaginalis testis mesothelioma)
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Has the patient experienced disease progression while on PD-1 or PD-L1 inhibitor therapy (e.g., Opdivo, Infinzi)? ❑ Yes ❑ No
4. Is the patient currently receiving therapy with the requested medication? ❑ Yes ❑ No *If No, skip to diagnosis section.*
5. Has the patient experienced disease progression or an unacceptable toxicity while receiving therapy with the requested medication? ❑ Yes ❑ No *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Urothelial Carcinoma – Bladder Cancer, Urothelial Carcinoma – Primary Carcinoma of the Urethra, Urothelial Carcinoma – Upper Genitourinary Tract Tumors or Urothelial Carcinoma of the Prostate

6. Will the requested medication be used as a single agent? ❑ Yes ❑ No
7. What is the place in therapy in which the requested medication will be used? ❑ First line therapy ❑ Other _____
8. What is the clinical setting in which the requested medication will be used? ***Indicate ALL that apply.***
   - ❑ Stage II or Stage III disease
   - ❑ Locally advanced disease
   - ❑ Metastatic disease
   - ❑ Metastatic disease post-cystectomy
   - ❑ Local recurrence post-cystectomy
   - ❑ Recurrent disease
   - ❑ Muscle invasive local recurrence or persistent disease in a preserved bladder
   - ❑ Other _____
9. *If diagnosis is urothelial carcinoma-bladder cancer,* was the patient's tumor present following reassessment of tumor status 2-3 months after primary treatment with concurrent chemotherapy? ❑ Yes ❑ No
10. Is the patient eligible to receive cisplatin chemotherapy? ❑ Yes ❑ No
11. 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 submit test results confirming PD-L1 tumor expression and no further questions.*** ❑ Yes ❑ No ❑ Unknown
12. Is the patient eligible to receive any platinum containing chemotherapy? ❑ Yes ❑ No

Section B: Non-Small Cell Lung Cancer (NSCLC)

13. What is the clinical setting in which the requested medication will be used? ❑ Recurrent disease ❑ Metastatic disease ❑ Advanced disease ❑ Other _____
14. Is the patient's disease positive for EGFR or ALK genomic tumor aberrations? ❑ Yes ❑ No

15. What regimen will the requested medication be used as?
    - ❑ Single agent
    - ❑ In combo with carboplatin, paclitaxel, bevacizumab, *skip to #18*
    - ❑ In combo with paclitaxel protein-bound and carboplatin, *skip to #18*

16. What is the place in therapy in which the requested medication will be used?
    ❑ Subsequent therapy, *no further questions* ❑ First line therapy

17. Does the patient's tumor have high PD-L1 expression (PD-L1 stained greater than or equal to 50% of tumor cells [TC greater than or equal to 50%] or PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 10% of the tumor area [IC greater than or equal to 10%])? ***ACTION REQUIRED: If Yes, please submit test results confirming PD-L1 tumor expression.*** ❑ Yes ❑ No *No further questions*

18. Did the patient receive previous treatment that targeted the EGFR or ALK genomic tumor aberrations?
    ❑ Yes ❑ No

19. What is the tumor's histology? ❑ Non-squamous ❑ Squamous ❑ Unknown

Section C: Breast Cancer

20. What is the clinical setting in which the requested medication will be used?
    ❑ Unresectable locally advanced disease ❑ Recurrent disease
    ❑ Metastatic disease ❑ Other _____

21. Will the requested medication will be used in combination with protein-bound paclitaxel? ❑ Yes ❑ No

22. Does the tumor express programmed death ligand 1 (PD-L1) (i.e., PD-L1 stained tumor- infiltrating immune cells [IC] of any intensity covering at least 1 percent of the tumor area)? ***ACTION REQUIRED: If Yes, please submit test results confirming PD-L1 tumor expression.*** ❑ Yes ❑ No ❑ Unknown

23. Is the patient's diagnosis confirmed by the breast cancer cells testing negative for ALL of the following receptors? ***ACTION REQUIRED: If Yes, please submit test results confirming triple negative breast cancer.***
    a) Human epidermal growth factor receptor 2 (HER-2) b) Estrogen c) Progesterone
    ❑ Yes ❑ No ❑ Unknown

Section D: Small Cell Lung Cancer

24. Does the patient have extensive-stage disease? ❑ Yes ❑ No

25. Will the requested medication be used in combination with etoposide and carboplatin (followed by single agent maintenance)? ❑ Yes ❑ No

26. Will the requested medication be used for initial treatment? ❑ Yes ❑ No

Section E: Hepatocellular Carcinoma

27. Will the requested medication be used for initial treatment? ❑ Yes ❑ No

28. Will the requested medication be used in combination with bevacizumab? ❑ Yes ❑ No

Section F: Melanoma

29. What is the clinical setting in which the requested medication will be used?
    - ❑ Unresectable disease
    - ❑ Metastatic disease
    - ❑ Other _____

30. Is the tumor positive for BRAF V600 mutation? ***ACTION REQUIRED: If Yes, please submit test results confirming BRAF V600 mutation.*** ❑ Yes ❑ No ❑ Unknown

31. Will the requested medication be used in combination with cobimetinib (Cotellic) and vemurafenib (Zelboraf)?
    ❑ Yes ❑ No

Section G: Mesothelioma (malignant peritoneal mesothelioma, pericardial mesothelioma, or tunica vaginalis testis mesothelioma

32. Please indicate the type of mesothelioma the patient has:
    - ❑ Malignant peritoneal mesothelioma
    - ❑ Pericardial mesothelioma
    - ❑ Tunica vaginalis testis mesothelioma
    - ❑ Other

33. What is the place in therapy in which the requested drug will be used?
    - ❑ First-line therapy
    - ❑ Subsequent therapy

34. Will the requested drug be used in combination with bevacizumab? ❑ Yes ❑ No

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