

Tecentriq
Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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 **1-866-814-5506**. 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 Inpatient Hospital Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Tecentriq SGM – 8/2018.

CVS Caremark is an independent company that provides pharmacy benefit management services to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. members.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). © Registered trademark of the Blue Cross and Blue Shield Association

Criteria Questions:

1. What is the diagnosis?
 Locally advanced or metastatic urothelial carcinoma
 Metastatic non-small cell lung cancer (NSCLC)
 Other _____
2. What is the ICD-10 code? _____
3. Has the disease progressed during or following platinum-containing chemotherapy? Yes No

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

Section A: Locally Advanced or Metastatic Urothelial Carcinoma

4. Is the patient eligible or ineligible for platinum-containing chemotherapy?
 Eligible Ineligible *If Ineligible, No further questions*
5. Is the patient ALSO eligible or ineligible for cisplatin-containing chemotherapy?
 Eligible *If Eligible, skip to #7* Ineligible
6. Does the patient's tumor express PD-L1 (PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 5 percent of the tumor area) as determined by an FDA-approved test?
 Yes *If Yes, No further questions* No
7. Has the patient experienced disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy? Yes No

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

8. Is the patient positive for either an EGFR mutation or ALK gene rearrangement?
 Yes No *If No, No further questions*
9. Has the disease progressed on FDA-approved therapy (e.g., erlotinib [Tarceva], afatinib [Gilotrif], gefitinib [Iressa], crizotinib [Xalkori], ceritinib [Zykadia]) for EGFR mutation positive or ALK gene rearrangement positive NSCLC? 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)