

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-844-723-2094. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay the authorization process.*

Drug Requested: **TECENTRIQ® (atezolizumab) (IV) (J9999) (Medical)**

DRUG INFORMATION: Information below **must** be completed or authorization process will be delayed.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

CLINICAL CRITERIA: Check **all** that apply. To qualify, applicable boxes **must** be checked.

- Locally advanced or metastatic urothelial carcinoma:
 - Have disease progression during or following platinum-containing chemotherapy
 - Have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.

OR

- Metastatic non-small cell lung cancer
 - Have disease progression during or following platinum-containing chemotherapy. *Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA approved therapy for these aberrations prior to receiving Tecentriq®.*

Medication being provided by (check applicable box below):

- Location/site of drug administration: _____
NPI or DEA # of administering location: _____

OR

- Specialty Pharmacy - PropriumRx

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____