

OPTIMA HEALTH COMMUNITY CARE

(MEDICAID)

PHARMACY/MEDICAL 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 1-844-348-3720.** 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: Complete information below or authorization will be delayed.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

CLINICAL CRITERIA: Check **all** that apply to ensure authorization will **NOT** to be delayed.

- 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

(Continued on next page; Signature page **MUST** be attached to this request.)

(Signature page **MUST** be included with this request.)

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 #: _____

REVISED/UPDATED: 8/1/2017; 5/25/2018; 8/31/2018; 10/9/2018; (REFORMATTED) 2/5/2019