OPTIMA HEALTH COMMUNITY CARE

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 1-844-348-3720. 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: 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. Applicable boxes must be checked to qualify.

- ❑ 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):

- ❑ **Physician's office**

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 #: _____

REVISED/UPDATED: 8/1/2017