

OPTIMA HEALTH PLAN

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 1-844-202-5034. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay 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 or authorization process will 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):

- Physician's office

OR

- Specialty Pharmacy: Briova SpecialtyRx

****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 #: _____