Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Tecentriq
(atezolizumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Tecentriq 840mg/14ml vial ☐ Tecentriq 1200mg/20ml vial ICD10:

Dose: Frequency of therapy: Duration of therapy:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*

Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting (such as AIS, MDO, home) with assistance of a Specialty Care Option Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? Yes ☐ No ☐

What is your patient's diagnosis?
☐ Alveolar soft part sarcoma (ASPS)
☐ Chronic Lymphocytic Leukemia (CLL)
☐ Colon cancer
☐ hepatocellular carcinoma (HCC)
☐ melanoma
☐ muscle invasive bladder cancer (MIBC)
☐ non-small cell lung cancer (NSCLC)
☐ Peritoneal mesothelioma
☐ Small bowel adenocarcinoma
☐ small cell lung cancer (SCLC)
☐ Small cell neuroendocrine carcinoma of the cervix (NECC)
☐ Thymomas and Thymic Carcinomas
☐ urothelial carcinoma
☐ other

Clinical Information

If alveolar soft part sarcoma (ASPS):

Does the patient have unresectable or metastatic disease? Yes ☐ No ☐

If hepatocellular carcinoma (HCC):

Does the patient have unresectable or metastatic disease? Yes ☐ No ☐

Has the patient received systemic therapy for this diagnosis before requesting this medication? Yes ☐ No ☐

Will the requested medication be used in combination with bevacizumab? Yes ☐ No ☐

If melanoma:

Does the patient have BRAF V600 disease? Yes ☐ No ☐

Does the patient have unresectable or metastatic disease? Yes ☐ No ☐

Will the requested medication be used in combination with Cotellic (cobimetinib) and Zelboraf (vemurafenib)? Yes ☐ No ☐

If muscle invasive bladder cancer (MIBC):

Will the requested medication be used as single agent therapy? Yes ☐ No ☐

Will the requested medication be used as adjuvant treatment for this diagnosis? Yes ☐ No ☐
Is the requested medication to be given after cystectomy? Yes ☐ No ☐

Does the patient have circulating tumor DNA molecular residual diease (ctDNA MRD)? Yes ☐ No ☐

If non-small cell lung cancer (NSCLC):

Does the patient have stage II (2) (including IIA or IIB) or stage IIIA (3A) disease with programmed cell death ligand 1 (PD-L1) expression in greater than or equal to 1% or more of the tumor cells? Yes ☐ No ☐

Is the requested medication being used as adjuvant treatment (that is treatment given after the main treatment to reduce the chance of cancer coming back by destroying any remaining cancer cells) following resection of the tumor and platinum-based chemotherapy (such as carboplatin, cisplatin)? Yes ☐ No ☐

(if not stage II or IIIA for NSCLC) Does the patient have metastatic disease? Yes ☐ No ☐

Has the patient previously received a systemic immune checkpoint inhibitor (such as Keytruda, Opdivo)? Yes ☐ No ☐

Did the patient have disease progression during or after treatment with platinum-based chemotherapy (like carboplatin, cisplatin)? Yes ☐ No ☐

Which of the following does the patient have?
☐ EGFR (epidermal growth factor receptor)-positive
☐ ALK (anaplastic lymphoma kinase)-positive
☐ Testing did not indicate either EGFR (epidermal growth factor receptor) OR ALK (anaplastic lymphoma kinase) genomic mutations

(if EGFR-positive) Did the patient have disease progression while on Tarceva (erlotinib), Gilotrif (afatinib), Iressa (gefitinib), Tagrisso (osimertinib), or Portrazza (necitumumab)? Yes ☐ No ☐

(if ALK-positive) Did the patient have disease progression while on Xalkori (crizotinib), Zykadia (certinib), or Alecensa (alectinib)? Yes ☐ No ☐
(If no EGFR or ALK mutation) Is the requested medication for first line treatment? Yes ☐ No ☐

(if no EGFR or ALK mutations) Will the requested medication be used in combination with Avastin (bevacizumab), paclitaxel, and carboplatin? Yes ☐ No ☐

(if not in combo with Avastin [bevacizumab], paclitaxel, and carboplatin) Will the requested medication be used in combination with paclitaxel and carboplatin? Yes ☐ No ☐

(if not in combo with paclitaxel and carboplatin) Does the patient's tumors have high programmed cell death ligand 1 (PD-L1) expression (PD-L1 stained greater than or equal to 50% of tumor cells [TC greater than or equal to 50%] or PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 10% of the tumor area [IC greater than or equal to 10%])? Yes ☐ No ☐

If peritoneal mesothelioma:

Is the requested medication being used as subsequent (after first-line) systemic therapy? Yes ☐ No ☐
Is the patient's Eastern Cooperative Oncology Group (ECOG) Performance Status (PS) 0-2? Yes ☐ No ☐

Was the patient previously treated with immune checkpoint inhibitors? Yes ☐ No ☐

Will the requested medication be used in combination with bevacizumab? Yes ☐ No ☐

If small bowel adenocarcinoma:

Does the patient have deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) disease OR polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype (for example, tumor mutational burden greater than 50 mut/Mb)? Yes ☐ No ☐

If small cell lung cancer (SCLC):

Does the patient have extensive stage (Stage 4) disease (ES-SCLC)? Yes ☐ No ☐

Is the requested medication being used for for first line therapy? Yes ☐ No ☐

(if yes) Will the requested medication be used in combination with carboplatin and etoposide? Yes ☐ No ☐

(if NOT first line) Did the patient have progression after first-line induction therapy with carboplatin and etoposide? Yes ☐ No ☐

(if no) Will the requested medication be used in combination with lurbinectedin as maintenance therapy? Yes ☐ No ☐

If small cell neuroendocrine carcinoma of the cervix (NECC):

Does the patient have persistent, recurrent or metastatic disease? Yes ☐ No ☐

Will the requested be used in combination with cisplatin or carboplatin and etoposide? Yes ☐ No ☐

Will the requested medication be continued as a single agent for maintenance therapy? Yes ☐ No ☐

If urothelial carcinoma:

Does the patient have locally advanced, recurrent or metastatic disease? Yes ☐ No ☐

Is the patient ineligible for treatment with cisplatin regardless of level or tumor programmed cell death ligand 1 (PD-L1) expression? Yes ☐ No ☐

Did the patient have disease progression during or after treatment with platinum-based chemotherapy (for example, carboplatin, cisplatin)? Yes ☐ No ☐

If colon cancer:

Will the requested medication be used as adjuvant treatment in combination with FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CAPEOX (capecitabine and oxaliplatin) regimens? Yes ☐ No ☐

Does the patient have deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) disease OR polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype (for example, tumor mutational burden greater than 50 mut/Mb)? Yes ☐ No ☐

If Chronic Lymphocytic Leukemia (CLL):

Does the patient have Richter's transformation? Yes ☐ No ☐

Will the requested medication be used as part of a Non-chemoimmunotherapy (Immune Checkpoint Inhibitor)-based regimen in combination with venetoclax and obinutuzumab? Yes ☐ No ☐

Is the patient's CLL untreated? Yes ☐ No ☐

(if no) Is the patient's CLL clonally unrelated disease at initial diagnosis? Yes ☐ No ☐

(if yes) Will the requested medication be used as additional therapy for partial response, refractory disease, or progression while on treatment with chemoimmunotherapy regimens? Yes ☐ No ☐

(if NOT clonally unrelated) Is the patient's CLL previously treated AND clonally related (or clonal relation is unknown)? Yes ☐ No ☐

(if yes) Will the requested medication be used as first line treatment? Yes ☐ No ☐

(if no) Will the requested medication be used as continuation therapy for complete response until progression, or as additional therapy not previously used for partial response, refractory disease, or progression while on treatment with CIT or non-CIT regimens? Yes ☐ No ☐

If Thymomas/Thymic Carcinomas:

Will the requested medication be used as first-line systemic therapy in combination with carboplatin and paclitaxel? Yes ☐ No ☐

(if yes) Does the patient have recurrent, advanced, or metastatic disease? Yes ☐ No ☐

Has the patient had surgery for solitary metastasis or ipsilateral pleural metastasis? Yes ☐ No ☐

Does the patient have medically inoperable/unresectable solitary metastasis or ipsilateral pleural metastasis? Yes ☐ No ☐

(if no) Will the requested medication be used as postoperative systemic therapy in combination with carboplatin and paclitaxel after R1 or R2 resection? Yes ☐ No ☐

(if no) Does the patient have extrathoracic metastatic disease? Yes ☐ No ☐

Additional pertinent information

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

v080126

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include, for example, Cigna Health and Life Insurance Company and Cigna Health Management, Inc. Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005