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 (1640 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*
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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?
☐ hepatocellular carcinoma (HCC)
☐ breast cancer
☐ small cell lung cancer (SCLC)
☐ melanoma
☐ non-small cell lung cancer (NSCLC)
☐ urothelial cell carcinoma (UCC, also transitional cell carcinoma, TCC)
☐ other *(please specify):*

Clinical Information
Is this new start or continuation of therapy? ☐ new start ☐ continued therapy
(if continued therapy) Is your patient having a beneficial response to therapy with the requested drug? Yes ☐ No ☐

(if melanoma) Does your patient have BRAF V600 mutation-positive disease? Yes ☐ No ☐
(if melanoma) Does your patient have unresectable or metastatic disease? Yes ☐ No ☐
(if melanoma) Will the drug requested be taken in combination with cobimetinib (Cotellic) and vemurafenib (Zelboraf)? Yes ☐ No ☐
(if breast cancer) Does your patient have metastatic OR unresectable locally advanced disease? Yes ☐ No ☐

(if breast cancer) Does your patient have triple negative disease (tumor is estrogen receptor negative, progesterone receptor negative, and human epidermal growth factor receptor 2 [HER2] negative)? Yes ☐ No ☐
(if breast cancer) Is your patient's tumor expressing PD-L1? Yes ☐ No ☐
(if breast cancer) Will/Is the drug requested be(ing) used in combination with Abraxane? Yes ☐ No ☐

(if HCC) Does your patient have unresectable or metastatic disease? Yes ☐ No ☐
(if HCC) Has your patient received systemic therapy for this diagnosis before requesting this drug? Yes ☐ No ☐
(if HCC) Is/Will the drug requested (be)ing used in combination with bevacizumab (Avastin, Mvasi, Zirabev)? Yes ☐ No ☐

(if SCLC) Does your patient have extensive stage (Stage 4) disease (ES-SCLC)? Yes ☐ No ☐
(if SCLC) Will/Was the drug requested (be) used in combination with carboplatin and etoposide (Etopophos or Toposar) for first 4 cycles of therapy? Yes ☐ No ☐
(if SCLC) Is the drug requested being used as part of first line therapy? Yes ☐ No ☐

(if NSCLC) Does your patient have metastatic disease? Yes ☐ No ☐

(if UCC) Does your patient have locally advanced, recurrent or metastatic disease? Yes ☐ No ☐
(if UCC) Is your patient ineligible for treatment with cisplatin? Yes ☐ No ☐

(if NSCLC) Does your patient have one of the following gene mutations?
☐ EGFR (epidermal growth factor)-positive
☐ ALK (anaplastic lymphoma kinase)-positive
☐ Testing did not indicate either EGFR mutation- or ALK-positive disease
☐ Molecular testing was not done
(if EGFR-positive) Did your patient have disease progression while on either Tarceva, Gilotrif, Iressa, Tagrisso, or Portrazza? Yes ☐ No ☐
(if ALK-positive) Did your patient have disease progression while on either Xalkori, Zykadia, or Alecensa? Yes ☐ No ☐

(if NSCLC) Has your patient previously received a systemic immune checkpoint inhibitor (such as Keytruda, Opdivo)? Yes ☐ No ☐
(if NSCLC or UCC and not ineligible for cisplatin) Did your patient have disease progression after treatment with platinum-based chemotherapy (i.e. like carboplatin, cisplatin)? Yes ☐ No ☐
(if no EGFR or ALK mutation) Is the drug requested the first treatment your patient has received for this diagnosis? Yes ☐ No ☐
(if no EGFR or ALK mutation) Is/Will the drug requested be(ing) used in combination with Avastin, paclitaxel, and carboplatin? Yes ☐ No ☐
(if not in combo with bevacizumab, paclitaxel, and carboplatin) Is/Will the drug requested be(ing) used in combination with paclitaxel protein-bound (Abraxane) and carboplatin? Yes ☐ No ☐
(if not in combo with paclitaxel protein-bound and carboplatin) Does your patient's tumors have high PD-L1 expression (PD-L1 stained greater than or equal to 50% of tumor cells [TC ≥ 50%] or PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 10% of the tumor area [IC ≥ 10%)? Yes ☐ No ☐

Additional pertinent information *(including disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

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:**_____

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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.

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