Tecentriq

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Site of Service Questions (SOS):

A. Where will this drug be administered?
- ❑ On Campus Outpatient Hospital, *continue to B*
- ❑ Off Campus Outpatient Hospital, *continue to B*
- ❑ Home infusion, *skip to Criteria Questions*
- ❑ Physician office, *skip to Criteria Questions*
- ❑ Ambulatory surgical, *skip to Criteria Questions*
- ❑ Pharmacy, *skip to Criteria Questions.*

B. Is the patient less than 14 years of age?
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to C*

C. Is the patient receiving provider-administered combination oncology therapy or other provider-administered drug therapies at the same visit? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to D*

D. Is this request to continue previously established treatment with the requested regimen?
- ❑ No – This is a new therapy request (patient has not received 6 months or more of requested regimen). ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of existing treatment (patient has received requested regimen for 6 months). ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of an existing treatment (patient has received requested regimen for 7 months or greater – initial 6 months plus 45 days grace period), *Continue to E*

E. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre- medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to F*

F. Has the patient experienced severe toxicity requiring continuous monitoring (e.g. Grade 2-4 bullous dermatitis, transaminitis, pneumonitis, Stevens-Johnson syndrome, acute pancreatitis, primary adrenal insufficiency aseptic meningitis, encephalitis, transverse myelitis, myocarditis, pericarditis, arrhythmias, impaired ventricular function, or conduction abnormalities)? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to G*

G. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to H*

H. Does the patient have severe venous access issues that require the use of a special intervention only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to I*

I. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?
ACTION REQUIRED: If Yes, please attach supporting clinical documentation. ❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to J*

J. Are ***all*** alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) **greater than** 30 miles from the patient's home? ***ACTION REQUIRED: If Yes, please attach supporting documentation.***
❑ Yes, *Continue to Clinical Criteria Questions* ❑ No, *Continue to Clinical Criteria Questions*

Criteria Questions:

1. What is the diagnosis?

❒ Alveolar soft part sarcoma (ASPS), *Continue to 2*

❒ Cervical Cancer, *Continue to 2*

❒ Hepatocellular carcinoma (HCC), *Continue to 2*

❒ Melanoma, *Continue to 2*

❒ Mesothelioma (peritoneal mesothelioma, pericardial mesothelioma, or tunica vaginalis testis mesothelioma), *Continue to 2*

❒ Non-small cell lung cancer (NSCLC), *Continue to 2*

❒ Small cell lung cancer (SCLC), *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Has the patient experienced disease progression while on PD-1 or PD-L1 inhibitor therapy (e.g., Opdivo, Imfinzi)?

❒ Yes, *Continue to 3*

❒ No, *Continue to 3*

3. Is the patient currently receiving therapy with the requested medication?

❒ Yes, *Continue to 4*

❒ No, *Continue to 8*

4. Is this request for adjuvant treatment of hepatocellular carcinoma (HCC) or non-small cell lung cancer (NSCLC)?

❒ Yes, *Continue to 5*

❒ No, *Continue to 7*

5. Is there evidence of disease progression or unacceptable toxicity while on the current regimen?

❒ Yes, *Continue to 6*

❒ No, *Continue to 6*

6. How many continuous months of treatment has the patient received with the requested medication?

_____months, *No further questions*

7. Is there evidence of disease progression or unacceptable toxicity while on the current regimen?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

8. What is the diagnosis?

❒ Alveolar soft part sarcoma (ASPS), *Continue to 34*

❒ Cervical Cancer, *Continue to 36*

❒ Hepatocellular carcinoma (HCC), *Continue to 25*

❒ Melanoma, *Continue to 29*

❒ Non-small cell lung cancer (NSCLC), *Continue to 9*

❒ Pericardial Mesothelioma, *Continue to 32*

❒ Peritoneal Mesothelioma, *Continue to 32*

❒ Small cell lung cancer (SCLC), *Continue to 22*

❒ Tunica Vaginalis Testis Mesothelioma, *Continue to 32*

9. What is the clinical setting in which the requested medication will be used?

❒ Advanced disease, *Continue to 10*

❒ Metastatic disease, *Continue to 10*

❒ Recurrent disease, *Continue to 10*

❒ Stage II to III disease, *Continue to 19*

❒ Other, please specify. _____, *No further questions*

10. Is the tumor negative for EGFR exon 19 deletions, L858R mutations, and ALK rearrangements? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or test results of EGFR exon 19 deletions, L858R mutations, and ALK rearrangements.

❒ Yes, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 14*

❒ No, *Continue to 12*

❒ Unknown, *Continue to 11*

11. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?

❒ Yes, *Continue to 14*

❒ No, *Continue to 12*

12. Will the requested medication be used as a single agent?

❒ Yes, *Continue to 13*

❒ No, *Continue to 13*

13. What is the place in therapy in which the requested medication will be used?

❒ Initial treatment, *No further questions*

❒ Subsequent treatment, *No further questions*

14. What is the place in therapy in which the requested medication will be used?

❒ *Continued maintenance therapy, Continue to 15*

❒ First-line therapy, *Continue to 16*

❒ Subsequent therapy, *Continue to 18*

❒ Other, please specify. _____, *No further questions*

15. What is the requested regimen?

❒ Single agent, *No further questions*

❒ In combination with bevacizumab, *No further questions*

❒ Other, please specify. _____, *No further questions*

16. What is the requested regimen?

❒ Single agent, *Continue to 17*

❒ In combination with chemotherapy with or without bevacizumab, *No further questions*

❒ Other, please specify. _____, *No further questions*

17. Is the tumor PD-L1 expression positive (greater than or equal to 50%)? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or test results confirming PD-L1 positive status.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ No, *No further questions*

❒ Unknown, *No further questions*

18. What is the requested regimen?

❒ Single agent, *No further questions*

❒ In combination with chemotherapy, *No further questions*

❒ Other, please specify. _____, *No further questions*

19. Will the requested drug be used as adjuvant treatment?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Is the patient's tumor PD-L1 positive? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or test results confirming PD-L1 positive status.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 21*

❒ No, *Continue to 21*

❒ Unknown, *Continue to 21*

21. Will the requested medication be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

22. Does the patient have extensive-stage disease?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Will the requested medication be used in combination with etoposide and carboplatin (followed by single agent maintenance)?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Will the requested medication be used for initial treatment?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

25. What is the place in therapy in which the requested medication will be used?

❒ Initial treatment, *Continue to 26*

❒ Adjuvant treatment, *Continue to 27*

❒ Other, please specify. _____, *No further questions*

26. What is the clinical setting in which the requested medication will be used?

❒ Disease with extensive liver tumor burden, *Continue to 28*

❒ Inoperable disease, *Continue to 28*

❒ Metastatic disease, *Continue to 28*

❒ Unresectable disease, *Continue to 28*

❒ Other, please specify. _____, *Continue to 28*

27. Will the requested medication be used following resection or ablation?
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. Will the requested medication be used in combination with bevacizumab (Avastin)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

29. What is the clinical setting in which the requested medication will be used?

❒ Metastatic disease, *Continue to 30*

❒ Unresectable disease, *Continue to 30*

❒ Other, please specify. _____, *Continue to 30*

30. Is the tumor positive for BRAF V600 mutation? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or test results confirming BRAF V600 mutation.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 31*

❒ No, *Continue to 31*

❒ Unknown, *Continue to 31*

31. Will the requested medication be used in combination with cobimetinib (Cotellic) and vemurafenib (Zelboraf)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

32. What is the place in therapy in which the requested medication will be used?

❒ First-line treatment, *Continue to 33*

❒ Subsequent treatment, *Continue to 33*

33. Will the requested medication be used in combination with bevacizumab (Avastin)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

34. What is the clinical setting in which the requested medication will be used?

❒ Metastatic disease, *Continue to 35*

❒ Unresectable disease, *Continue to 35*

❒ Other, please specify. _____, *Continue to 35*

35. Will the requested medication be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

36. Is the requested medication being used to treat small cell neuroendocrine carcinoma of the cervix (NECC)?
❒ Yes, *Continue to 37*
❒ No, *Continue to 37*

37. Will the requested medication be used in combination with etoposide and either cisplatin or carboplatin?
❒ Yes, *Continue to 38*
❒ No, *Continue to 38*

38. What is the clinical setting in which the requested medication will be used?
❒ Metastatic disease, *No further questions*
❒ Persistent disease, *No further questions*
❒ Recurrent disease, *No further questions*
❒ Other, please specify. _____, *No further questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720