BlueCross BlueShield Federal Employee Program

TECENTRIQ
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Tecentriq (atezolizumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Tecentriq continuously for the last **4 months**, excluding samples? ***Please select answer below:***
   ❑ **YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑ Brand ❑ Generic
3. Does the prescriber agree to monitor the patient's liver enzymes including ALT, AST, and bilirubin? ❑Yes ❑No
4. Does the prescriber agree to monitor the patient for immune-related toxicities? ❑Yes ❑No
5. What is the patient's diagnosis?
   ❑ Alveolar Soft Part Sarcoma (ASPS)
      a. Does the patient have unresectable or metastatic alveolar soft part sarcoma? ❑Yes ❑No
   ❑ Extensive-Stage Small Cell Lung Cancer (ES-SCLC)
      a. Is Tecentriq being used as a first line treatment? ❑Yes ❑No
      b. Will Tecentriq be used in combination with carboplatin and etoposide? ❑Yes ❑No
   ❑ Hepatocellular Carcinoma (HCC)
      a. Does the patient have either metastatic or unresectable hepatocellular carcinoma? ❑Yes ❑No
      b. Has the patient received prior systemic therapy? ❑Yes ❑No
      c. Will Tecentriq be used as monotherapy? ❑Yes ❑No*****
         ****If NO***, will Tecentriq be used in combination with bevacizumab (Avastin)? ❑Yes ❑No
   ❑ Melanoma
      a. Does the patient have unresectable or metastatic melanoma? ❑Yes ❑No
      b. Will Tecentriq be used in combination with cobimetinib (Cotellic) and vemurafenib (Zelboraf)? ❑Yes ❑No
      c. Is the patient positive for the BRAF V600 mutation as determined by an FDA-approved test? ❑Yes ❑No
   ❑ Metastatic Non-Small Cell Lung Cancer (NSCLC)
      a. Is the patient negative for EGFR or ALK tumor expression? ***Please select answer below:***
         ❑ **Yes**: Has the patient had disease progression during or following platinum-containing chemotherapy? ❑Yes ❑No*****
            ****If NO***, is Tecentriq being used as first line therapy in patients with tumors that have high PD-L1 expression as determined by an FDA approved test? ❑Yes ❑No
         ❑ **No**: Has the patient had disease progression after targeted FDA approved therapy? ❑Yes ❑No*****
            ****If NO***, has the patient had disease progression while on or after a platinum-containing chemotherapy? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑ Metastatic non-squamous Non-Small Cell Lung Cancer (NSCLC)

a. Is the patient negative for EGFR or ALK tumor expression? ❑Yes* ❑No

If YES, will Tecentriq be used as first line treatment? ❑Yes ❑No

b. Will Tecentriq be used in combination with one of the following: bevacizumab (Avastin), paclitaxel (Taxol, Onxal), and carboplatin (Paraplatin) **OR** paclitaxel protein-bound (Abraxane) and carboplatin (Paraplatin)? ❑Yes ❑No

❑ Stage II to IIIA Non-Small Cell Lung Cancer (NSCLC)

a. Will Tecentriq be used as adjuvant treatment following resection and platinum-based chemotherapy? ❑Yes ❑No

b. Does the patient have PD-L1 expression on greater than or equal to 1% of tumor cells as determined by an FDA-approved test? ❑Yes ❑No

❑ Other diagnosis ***(please specify)***: _____

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Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Tecentriq (atezolizumab)

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on Tecentriq continuously for the last **4 months**, excluding samples? ***Please select answer below:***
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑ **YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑ Brand ❑ Generic

3. What is the patient's diagnosis?
   ❑ Extensive-Stage Small Cell Lung Cancer (ES-SCLC)
   ❑ Metastatic Alveolar Soft Part Sarcoma (ASPS)
   ❑ Unresectable Alveolar Soft Part Sarcoma (ASPS)
   ❑ Metastatic Hepatocellular Carcinoma (HCC)
   ❑ Unresectable Hepatocellular Carcinoma (HCC)
   ❑ Metastatic melanoma
   ❑ Unresectable melanoma
   ❑ Metastatic Non-Small Cell Lung Cancer (NSCLC)
   ❑ Metastatic non-squamous Non-Small Cell Lung Cancer (NSCLC)
   ❑ Other diagnosis ***(please specify):*** _____

4. Has the patient experienced disease progression or unacceptable toxicity while on Tecentriq? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Tecentriq – FEP MD Fax Form Revised 1/13/2023