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)
☐ hepatocellular carcinoma (HCC)
☐ Non-small cell lung cancer
☐ Peritoneal mesothelioma
☐ small cell lung cancer (SCLC)
☐ Small cell neuroendocrine carcinoma of the cervix (NECC)
☐ urothelial carcinoma
☐ melanoma
☐ other *(please specify):*

Clinical Information

(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 ASPS or 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 medication? Yes ☐ No ☐

(if HCC) Is/Will the requested medication (be)ing used in combination with bevacizumab (Alymsys, Avastin, Mvasi, Vegzelma, Zirabev)? Yes ☐ No ☐

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

(if SCLC) Will/Was this medication (be) used in combination with carboplatin and etoposide (Etopophos or Toposar)? Yes ☐ No ☐

(if SCLC) Is this medication being used as part of first line therapy? Yes ☐ No ☐

(if NSCLC) Is this 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)? Yes ☐ No ☐

(if adjuvant treatment of NSCLC) Does the patient have stage II (2) (including IIA or IIB) or stage IIIA (3A) disease? Yes ☐ No ☐

(if adjuvant treatment of NSCLC) Does the patient have PD-L1 expression on 1% or more of the tumor cells? Yes ☐ No ☐

(if adjuvant treatment of NSCLC) Is this medication being requested AFTER resection of the tumor and platinum-based chemotherapy (such as carboplatin, cisplatin)? Yes ☐ No ☐

(if not adjuvant treatment for NSCLC) Does your patient have metastatic disease? Yes ☐ No ☐

(if urothelial) Does your patient have locally advanced, recurrent or metastatic disease? Yes ☐ No ☐

(if urothelial) Is your patient ineligible for treatment with cisplatin? Yes ☐ No ☐

(if metastatic 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, (erlotinib), Gilotrif, Iressa, (gefitinib), Tagrisso, or Portrazza? Yes ☐ No ☐

(if ALK-positive) Did your patient have disease progression while on either Xalkori, Zykadia, or Alecensa? Yes ☐ No ☐

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

(if metastatic NSCLC OR urothelial 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 this medication the first treatment your patient has received for this diagnosis? Yes ☐ No ☐

(if no EGFR or ALK mutation) Is/Will this medication be(ing) used in combination with Avastin (bevacizumab), paclitaxel, and carboplatin? Yes ☐ No ☐

(if not in combo with Avastin [bevacizumab], paclitaxel, and carboplatin) Is/Will this medication 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 ☐

(if NECC) Does your patient have persistent, recurrent or metastatic disease? Yes ☐ No ☐

(if NECC) Is/Will this medication (be)ing used in combination with cisplatin or carboplatin and etoposide? Yes ☐ No ☐

(if NECC) Will this medication be continued as a single agent for maintenance therapy? Yes ☐ No ☐

(if peritoneal mesothelioma) Is this medication being used for first-line systemic therapy or subsequent (after first-line) systemic therapy?

☐ First-line systemic therapy
☐ Subsequent systemic therapy

(if peritoneal mesothelioma) What is your patient's ECOG performance status (PS)?
☐ PS 0
☐ PS 1
☐ PS 2
☐ PS 3
☐ PS 4

(if peritoneal mesothelioma) Is/Will this medication (be)ing used in combination with bevacizumab (Alymsys, Avastin, Mvasi, Vegzelma, Zirabev)? Yes ☐ No ☐

(if peritoneal mesothelioma) Has your patient previously received a systemic immune checkpoint inhibitor (such as Keytruda, Opdivo)? 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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