Cigna®

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

# Tecentriq Hybreza

(atezolizumab and hyaluronidase-tqjs)

| 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 Hybreza
Other (please specify):

Directions for use: Dose and Quantity: Duration of therapy:

J-Code: ICD10:

**Where will this medication be obtained?**

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

***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):

**Where will this drug be administered?**

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

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

**Diagnosis related to use:**

☐ alveolar soft part sarcoma (ASPS)
☐ hepatocellular carcinoma (HCC)
☐ melanoma
☐ non-small cell lung cancer (NSCLC)
☐ peritoneal mesothelioma
☐ small cell lung cancer (SCLC)
☐ small cell neuroendocrine carcinoma of the cervix (NECC)
☐ Other (please specify):

**Clinical Information:**

(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 this medication (be)ing used in combination with bevacizumab (Alymsys, Avastin, Mvasi, Vegzelma, Zirabev)? ☐ 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 this medication be taken in combination with cobimetinib (Cotellic) and vemurafenib (Zelboraf)? ☐ Yes ☐ No

(if SCLC) Does your patient have extensive stage 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) Does your patient have metastatic disease? ☐ 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) Did your patient have disease progression during or after treatment with platinum-based chemotherapy (like carboplatin, cisplatin)? ☐ Yes ☐ No

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

(if disease progression NSCLC) Does your patient have one of the following gene mutations?
☐ EGFR (epidermal growth factor receptor)-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 1st line NSCLC) Does your patient have one of the following gene mutations?
☐ EGFR (epidermal growth factor receptor)-positive
☐ ALK (anaplastic lymphoma kinase)-positive
☐ Testing did not indicate either EGFR mutation- or ALK-positive disease
☐ Molecular testing was not done

(if 1st line NSCLC) Is this medication part of the first-line treatment your patient is receiving for this diagnosis? ☐ Yes ☐ No

(if 1st line NSCLC) Which of the following first-line treatments will your patient be using with this medication?
☐ Avastin (bevacizumab), paclitaxel, and carboplatin
☐ Paclitaxel protein-bound (Abraxane) and carboplatin
☐ Other or using alone

(if 1st line NSCLC) Do your patient's tumors have high 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 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
☐ Unknown

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

(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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