SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Tecentriq® (Atezolizumab) Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

☐ Physician billing (HCPCS code:_____) **Start Date *(or date of next dose):*** _____
Dose: _____ _____ ***Regimen:*** _____

Billing Provider Information

SoonerCare Provider ID: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate the diagnosis and information:
   - ☐ Non-Small Cell Lung Cancer (NSCLC)
     - A. Will atezolizumab be used for subsequent therapy for metastatic disease? Yes ___ No___
     - B. Please indicate member's ECOG performance score: _____
     - C. Will atezolizumab be used as a single-agent? Yes ___ No___
   - ☐ Urothelial Carcinoma
     - A. Is diagnosis locally advanced or metastatic urothelial carcinoma? Yes ___ No___
     - B. Did disease progress on or following platinum containing chemotherapy? Yes ___ No___
     - C. Is member ineligible for cisplatin? Yes ___ No___
   - ☐ If answer is none of the above, please indicate diagnosis:_____

Additional Information: _____
_____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on atezolizumab? Yes____ No____
3. Has the member experienced adverse drug reactions related to atezolizumab therapy? Yes____ No____

*If yes, please specify adverse reactions:*_____
_____
Additional Information: _____
_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*