Prescriber Criteria Form Tecentriq 2026 PA Fax 1374-A v1 010126.docx Tecentriq (atezolizumab) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Tecentriq (atezolizumab).

Drug Name: Tecentriq (atezolizumab)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of urothelial carcinoma? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of recurrent, advanced, or metastatic non-small cell lung cancer (NSCLC)? [If yes, then no further questions.]	Yes	No
3	Does the patient have a diagnosis of stage II to IIIB non-small cell lung cancer (NSCLC)? [If no, then skip to question 5.]	Yes	No
4	Will the requested drug be used as adjuvant treatment following resection and adjuvant chemotherapy? [No further questions.]	Yes	No
5	Does the patient have a diagnosis of extensive-stage small cell lung cancer (ES-SCLC)? [If no, then skip to question 8.]	Yes	No
6	Will the requested drug be used in combination with etoposide and carboplatin? [If yes, then no further questions.]	Yes	No
7	Is requested drug being used as single agent maintenance following combination treatment with etoposide and carboplatin? [No further questions.]	Yes	No

8	Does the patient have a diagnosis of hepatocellular carcinoma? [If no, then skip to question 10.]	Yes	No
9	Will the requested drug be used as initial treatment in combination with bevacizumab? [No further questions.]	Yes	No
10	Does the patient have a diagnosis of melanoma? [If no, then skip to question 14.]	Yes	No
11	Does the patient have unresectable or metastatic disease? [If no, then no further questions.]	Yes	No
12	Does the patient have BRAF V600 mutation-positive disease? [If no, then no further questions.]	Yes	No
13	Will the requested drug be used in combination with cobimetinib and vemurafenib? [No further questions.]	Yes	No
14	Does the patient have a diagnosis of peritoneal mesothelioma, pericardial mesothelioma, or tunica vaginalis testis mesothelioma? [If no, then skip to question 16.]	Yes	No
15	Will the requested drug be used as subsequent therapy? [No further questions.]	Yes	No
16	Does the patient have a diagnosis of alveolar soft part sarcoma? [If yes, then no further questions.]	Yes	No
17	Does the patient have a diagnosis of any of the following cervical cancer: A) persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix (NECC), B) squamous cell carcinoma, C) adenocarcinoma, D) adenosquamous cell carcinoma of the cervix?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____