OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Tecentriq® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Non-small cell lung cancer (NSCLC)
❑ Urothelial carcinoma
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is Tecentriq prescribed by or in consultation with an oncologist? ❑ **Yes** ❑ **No**
Is this request for continuation of prior Tecentriq therapy? ❑ **Yes** ❑ **No**
Has the patient been on Tecentriq within the past 120 days? ❑ **Yes** ❑ **No**

For non-small cell lung cancer (NSCLC), also answer the following:

Does the patient have metastatic disease? ❑ **Yes** ❑ **No**
Has the patient's disease progressed during or following any platinum-containing chemotherapy? ❑ **Yes** ❑ **No**
Does the patient have an epidermal growth factor receptor (EGFR) genomic tumor aberration? ❑ **Yes** ❑ **No**
Has the patient experienced disease progression on one anti-EGFR therapy [e.g., Gilotrif (afatinib), Iressa (gefitinib), Tarceva (erlotinib)]? ❑ **Yes** ❑ **No**
Does the patient have an anaplastic lymphoma kinase (ALK) genomic tumor aberration? ❑ **Yes** ❑ **No**
Has the patient experienced disease progression on one ALK inhibitor [e.g., Alecensa (alectinib), Xalkori (crizotinib), Zykadia (ceritinib)]? ❑ **Yes** ❑ **No**

For urothelial carcinoma, also answer the following:

Does the patient have locally advanced or metastatic urothelial carcinoma? ❑ **Yes** ❑ **No**
Does the patient have tumors that express PD-L1 (PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 5% of the tumor area), as determined by an FDA-approved test (e.g., Ventana PD-L1 Assay)? ❑ **Yes** ❑ **No**
Is the patient eligible for cisplatin-containing chemotherapy? ❑ **Yes** ❑ **No**
Has the patient's disease progressed during or following any platinum-containing chemotherapy? ❑ **Yes** ❑ **No**
Has the patient experienced disease progression within 12 months of neoadjuvant or adjuvant chemotherapy? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Tecentriq_CMS_2019Jan-W