OKLAHOMA Health Care Authority

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State of Oklahoma SoonerCare

Tevimbra® (tislelizumab-jsgr) 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

Provider NPI:_____ ***Provider Name:***_____

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

Prescriber Information

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

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

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:

☐ **Esophageal Cancer**

A. Is diagnosis unresectable or metastatic esophageal squamous cell carcinoma (ESCC)? Yes☐ No☐
B. Will Tevimbra® be used after disease progression on prior systemic chemotherapy? Yes☐ No☐
C. Has member previously failed other PD-1 or PD-L1 inhibitors? Yes☐ No☐
D. Will Tevimbra® be used as a single agent? Yes☐ No☐

☐ **Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma**

A. Is diagnosis unresectable or metastatic gastric or GEJ adenocarcinoma? Yes☐ No☐
B. Will Tevimbra® be used in the first-line setting in combination with platinum and fluoropyrimidine-based chemotherapy? Yes☐ No☐
C. Is disease human epidermal receptor 2 (HER2)-negative disease? Yes☐ No☐
D. Does tumor express programmed death ligand 1 (PD-L1) ≥1%? Yes☐ No☐

☐ **Other:** _____

Additional Information:_____

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on Tevimbra® therapy? Yes☐ No☐
3. Has member experienced any adverse drug reactions related to Tevimbra® therapy? Yes☐ No☐

If yes, please specify adverse reactions: _____

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.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *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.*