



MEDICATION POLICY

Generic Name: Atezolizumab

Therapeutic Class or Brand Name: Tecentriq®

Applicable Drugs (if Therapeutic Class): N/A

Date of Origin: 5/4/17

Date Last Reviewed/Revised: 4/18/18

GPI Code: 2135301500

Prior Authorization Criteria (may be considered medically necessary when criteria I through III are met):

- I. Documented diagnosis of one of the following conditions A through B AND must meet criteria listed under applicable diagnosis:
 - A. Locally advanced or metastatic urothelial carcinoma and criteria 1 and 2 are met:
 1. Documentation of one of the following a or b:
 - a. Patient is not eligible for cisplatin-containing chemotherapy.
 - b. Disease progression during or following any platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant chemotherapy.
 2. Tecentriq® will be used as a single agent.
 - B. Metastatic non-small cell lung cancer and criteria 1 through 3 are met:
 1. Documentation of disease progression during or following platinum-containing chemotherapy.
 2. If the patient has EGFR or ALK genomic tumor aberrations, documentation of disease progression on FDA-approved therapy for these aberrations.
 3. Tecentriq® will be used as a single agent.
- II. Minimum age requirement: 18 years old.
- III. Prescribing physician is an oncologist.

Exclusion Criteria:

- Prior treatment with a programmed death receptor-1 (PD-1)-blocking antibody or a programmed death-ligand 1 (PD-L1) blocking antibody (i.e. Bavencio®, Imfinzi™, Keytruda®, Opdivo®, or Tecentriq®).

Other Criteria:

- N/A

Disclaimer: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgment in providing the most appropriate care for their patients.



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Quantity/Days Supply Restrictions:

- 1200 mg every 3 weeks.

Approval Length:

- **Authorization:** 6 months.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing that current medical necessity criteria are met and that the medication is effective.

Appendix:

N/A

References:

1. https://www.gene.com/download/pdf/tecentriq_prescribing.pdf.
2. Medi-Span.
3. https://regence.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/Cambia/Program_Summaries/dru463reg.pdf
4. https://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/atezolizumab_tecentriq.pdf.

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<i>Historical Tracking Of Changes Made To Policy</i>	
4/18/18	<ol style="list-style-type: none">1. Added “Bavencio®” to “Prior treatment” list under Exclusion Criteria2. Deleted “http://blue.regence.com/trgmedpol/drugs/dru463.pdf.” and Added/Updated link https://regence.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/Cambia/Program_Summaries/dru463reg.pdf”
5/18/2017	<ol style="list-style-type: none">1. Added “Imfinzi™” to “Prior treatment” list under Exclusion Criteria.

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