Clinical Policy Title:	tazemetostat
Policy Number:	RxA.629
Drug(s) Applied:	Tazverik®
Original Policy Date:	05/21/2020
Last Review Date:	8/28/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Epithelioid Sarcoma (must meet all):

1. Member has epithelioid sarcoma that is not eligible for complete resection;
2. The member has histologically confirmed metastatic or locally advanced disease;
3. The member has loss of INI1 expression or mutation of INI1 gene (SMARCB-1) detected using local tests;
4. Tazverik® is prescribed as monotherapy.

Approval Duration

All Lines of Business (except Medicare): 6 months

B. Follicular Lymphoma (FL) (must meet all):

1. Diagnosis of relapsed or refractory FL;
2. Prescribed for the treatment of one of the following (a or b):
   a. EZH2 mutation positive relapsed/refractory disease as detected by FDA-approved test, after at least two prior systemic therapies (prescriber must provide supporting documentation of previous therapies);
   b. EZH2 wild-type or unknown relapsed/refractory disease and no satisfactory alternative treatment options as evidenced by supporting documentation.

Approval Duration

All Lines of Business (except Medicare): 6 months

II. Continued Therapy Approval

A. All Indications in Section I (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

Approval Duration:

All Lines of Business (except Medicare): 12 months

References

1. National Comprehensive Cancer Network. Soft Tissue Sarcoma. Version 2.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf. Accessed August 28, 2024.
2. National Comprehensive Cancer Network. B-Cell Lymphomas - Follicular Lymphoma. Version 3.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed August 28, 2024.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	5/2020	5/21/2020
Policy was reviewed: 1. Continuation therapy criteria II.A.1. rephrased to "Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria listed in this policy. 2. Continued therapy approval duration updated from 1 year to 12 months. 3. References were updated and point 3 reference added 4. Added initial approval criteria for new indication of relapsed or refractory follicular lymphoma. 5.	01/22/2020	03/09/2021
Policy was reviewed: 1. References were reviewed and updated.	12/13/2021	01/17/2022
Policy was reviewed: 1. Initial Approval Criteria, I.B.1: Updated to include diagnosis criteria Diagnosis of FL. 2. References were reviewed and updated.	10/20/2022	01/17/2023
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Removed age restrictions. 2. Removed prescriber restrictions. 3. Removed dose restrictions. 4. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 5. Removed reauthorization requirement for positive response to therapy. 6. Updated approval duration verbiage. 7. References were reviewed and updated.	8/28/2024	9/13/2024