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:** 5/18/17

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. Imfinzi™, Keytruda®, Opdivo®, or Tecentriq®).

Other Criteria:

- N/A

MEDICATION POLICY

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. http://blue.regence.com/trgmedpol/drugs/dru463.pdf.
4. https://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/atezolizumab_tecentriq.pdf.

MEDICATION POLICY

Historical Tracking Of Changes Made To Policy	
5/18/2017	1. **Added** "Imfinzi™" **to** "Prior treatment…" list **under Exclusion Criteria**.