

## PHARMACY POLICY STATEMENT

### Georgia Medicaid

DRUG NAME	Tecentriq (atezolizumab)
BILLING CODE	J9022 (1 unit = 10 mg)
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Outpatient
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— 1200 mg every 3 weeks
LIST OF DIAGNOSES CONSIDERED <b>NOT</b> MEDICALLY NECESSARY	<a href="#">Click Here</a>

Tecentriq (atezolizumab) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

#### NON-SMALL CELL LUNG CANCER (NSCLC)

For **initial** authorization:

1. Member must be 18 year of age or older; AND
2. Medication must be prescribed by oncologist/hematologist; AND
3. Member has metastatic disease progression during or following platinum-containing chemotherapy. Members with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving Tecentriq; AND
4. Member does **not** have ANY of the following:
  - a) History of autoimmune disease;
  - b) Had active or corticosteroid-dependent brain metastases;
  - c) Live attenuated vaccine administration within 28 days prior to therapy;
  - d) Systemic immunostimulatory agent administration within 4 weeks or systemic immunosuppressive medications within 2 weeks prior to treatment.
5. **Dosage allowed:** Intravenous infusion of 1200 mg every 3 weeks.

***If member meets all the requirements listed above, the medication will be approved for 6 months.***

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

***If member meets all the reauthorization requirements above, the medication will be approved.***

## UROTHELIAL CARCINOMA (UrC)

For **initial** authorization:

1. Member must be 18 year of age or older; AND
2. Medication must be prescribed by oncologist/hematologist; AND
3. Medication is being used for the treatment of patients with locally advanced or metastatic UrC who are not eligible for cisplatin-containing chemotherapy (i.e. impaired renal function (creatinine clearance of > 30 but < 60 mL/min), hearing loss of  $\geq 25$  dB at two contiguous frequencies, or  $\geq$  Grade 2 peripheral neuropathy); OR
4. Medication is being used for the treatment of patients with locally advanced or metastatic UrC who have disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy; AND
5. Member does **not** have ANY of the following:
  - a) History of autoimmune disease;
  - b) Active or corticosteroid dependent brain metastases;
  - c) Administration of a live, attenuated vaccine within 28 days prior to enrollment;
  - d) Administration of systemic immunostimulatory agents within 6 weeks or systemic immunosuppressive medications within 2 weeks prior to enrollment.
6. **Dosage allowed:** Intravenous infusion of 1200 mg every 3 weeks.

***If member meets all the requirements listed above, the medication will be approved for 6 months.***

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

***If member meets all the reauthorization requirements above, the medication will be approved.***

**CareSource considers Tecentriq (atezolizumab) not medically necessary for the treatment of the diseases that are not listed in this document.**

DATE	ACTION/DESCRIPTION
06/22/2017	New policy for Tecentriq created.

References:

1. Tecentriq [package insert]. South San Francisco, CA; Genentech, Inc.: April, 2017.

Effective date: 09/01/2017

Revised date: 06/22/2017