Humana. CareSource™

PHARMACY POLICY STATEMENT
Kentucky Medicaid

DRUG NAME	Tecentriq (atezolizumab)
BILLING CODE	J9999
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 **NOT** MEDICALLY NECESSARY	Click Here

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 ≥ 25 dB at two contiguous frequencies, or ≥ 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