**STANDARD COMMERCIAL DRUG FORMULARY**
**PRIOR AUTHORIZATION GUIDELINES**

**TAZEMETOSTAT**

| Generic | Brand | HICL | GCN | Medi-Span | Exception/Other |
|---|---|---|---|---|---|
| TAZEMETOSTAT | TAZVERIK | 46312 | | GPI-10 (2153367520) | |

## GUIDELINES FOR USE

1. Does the patient have a diagnosis of metastatic or locally advanced epithelioid sarcoma and meet **ALL** of the following criteria?
   - The patient is 16 years of age or older
   - The patient is not eligible for complete resection

   If yes, **approve for 12 months by HICL or GPI-10 with a quantity limit of #8 per day.**
   If no, continue to #2.

2. Does the patient have a diagnosis of relapsed or refractory follicular lymphoma **AND** meet the following criterion?
   - The patient is 18 years of age or older

   If yes, continue to #3.
   If no, do not approve.
   **DENIAL TEXT:** See the denial text at the end of the guideline.

3. Does the patient meet **ALL** of the following criteria?
   - The tumors are positive for an EZH2 mutation as detected by an FDA-approved test
   - The patient has received at least 2 prior systemic therapies

   If yes, **approve for 12 months by HICL or GPI-10 with a quantity limit of #8 per day.**
   If no, continue to #4.

4. Does the patient have no satisfactory alternative treatment options?

   If yes, **approve for 12 months by HICL or GPI-10 with a quantity limit of #8 per day.**
   If no, do not approve.
   **DENIAL TEXT:** See the denial text at the end of the guideline.

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# TAZEMETOSTAT

## GUIDELINES FOR USE (CONTINUED)

**DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.**

Our guideline named **TAZEMETOSTAT (Tazverik)** requires the following rule(s) be met for approval:

A. You have ONE of the following diagnoses:
   1. Metastatic or locally advanced (cancer that has spread to other parts of the body or has grown outside the organ it started in, but has not yet spread to distant parts of the body) epithelioid sarcoma (rare type of soft tissue cancer)
   2. Relapsed or refractory follicular lymphoma (cancer of the white blood cells that has returned or is resistant to previous treatment)

B. **If you have metastatic or locally advanced epithelioid sarcoma, approval also requires:**
   1. You are 16 years of age or older
   2. You are not eligible for complete resection (surgically removing all of a tissue/organ)

C. **If you have relapsed or refractory follicular lymphoma, approval also requires:**
   1. You are 18 years or older
   2. You meet ONE of the following:
      a. Your tumors are positive for an EZH2 (type of gene) mutation as detected by a Food and Drug Administration (FDA)-approved test AND you have received at least 2 prior systemic therapies (medication/treatment that spreads throughout your body)
      b. You have no satisfactory alternative treatment options

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

## RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Tazverik.

## REFERENCES


- Tazverik [Prescribing Information]. Cambridge, MA: Epizyme, Inc.; June 2020.


| Library | Commercial | NSA |
|---|---|---|
| Yes | Yes | No |

Part D Effective: N/A
Commercial Effective: 07/13/20
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P&T Approval: 07/20