PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Tazverik Prior Authorization Policy
- Tazverik® (tazemetostat tablets – Epizyme)

REVIEW DATE: 03/06/2024

OVERVIEW

Tazverik, an EZH2 inhibitor, is approved in the following conditions:[1]

- **Epithelioid sarcoma**, metastatic or locally advanced disease not eligible for complete resection in patients ≥ 16 years of age.
- **Follicular lymphoma**, in the following situations:
  - Relapsed or refractory disease, positive for an EZH2 mutation as detected by an approved test and in adults who have received at least two prior systemic therapies.
  - Relapsed or refractory disease, with no satisfactory alternative treatment options in adults.

These indications are approved under accelerated approval based on overall response rate and duration of response. Continued approval may be contingent upon verification and description of clinical benefit in confirmatory trial(s).

Guidelines

Tazverik is addressed in the following guidelines from the National Comprehensive Cancer Network:

- **Epithelioid Sarcoma:** Guidelines for soft tissue sarcoma (version 3.2023 – December 12, 2023) recommend Tazverik as a "Preferred" therapy (category 2A) for treatment of metastatic or locally advanced epithelioid sarcoma not eligible for complete resection.[2] No other therapies are listed for this specific subtype of soft tissue sarcoma.
- **Follicular Lymphoma:** Guidelines for B-cell lymphomas (version 1.2024 – January 18, 2024) recommend Tazverik as a third-line and subsequent therapy (category 2A) for follicular lymphoma, under "Other Recommended Regimen", irrespective of EZH2 mutation status.[3] Tazverik is a "Preferred Regimen" in the second-line setting for a patient who is elderly or infirm (irrespective of *EZH2* mutation status), and if none of the other therapies are expected to be tolerable in the opinion of the treating physician.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Tazverik. All approvals are provided for the duration noted below.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Tazverik is recommended in those who meet one of the following criteria:

FDA-Approved Indications

1. **Epithelioid Sarcoma.** Approve for 1 year if the patient meets the following (A, B, and C):
   - **A)** Patient is ≥ 16 years of age; AND
   - **B)** Patient has metastatic or locally advanced disease; AND
   - **C)** Patient is not eligible for complete resection.

2. **Follicular Lymphoma.** Approve for 1 year if the patient meets the following (A, B, and C):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has relapsed or refractory disease; AND
   - **C)** Patient meets ONE of the following (i or ii):
     - **i.** Patient has tried at least two prior systemic therapies; OR
     - **ii.** According to the prescriber, there are no appropriate alternative therapies.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Tazverik is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Tazverik® tablets [prescribing information]. Cambridge, MA: Epizyme; November 2023.
2. The NCCN Soft Tissue Sarcoma Clinical Practice Guidelines in Oncology (version 3.2023 – December 12, 2023). © 2023 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org/. Accessed on March 1, 2024.
3. The NCCN B-Cell Lymphoma Clinical Practice Guidelines in Oncology (version 1.2024 – January 18, 2024). © 2024 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org/. Accessed on March 1, 2024.