### Atezolizumab (Tecentriq™)

**Place of Service**  
Office Administration  
Infusion Center Administration  
Outpatient Facility Administration  

**HCPCS**: J9022 per 10 mg  

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#### Condition listed in policy (see criteria for details)
- Breast cancer (triple-negative)
- Cutaneous melanoma
- Hepatocellular carcinoma
- Non-small cell lung cancer
- Small cell lung cancer
- Urothelial carcinoma

**AHFS therapeutic class**: Antineoplastic  
**Mechanism of action**: Anti-PD-L1 monoclonal antibody

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#### (1) Special Instructions and Pertinent Information
**Covered under the Medical Benefit**, please submit clinical information for prior authorization review via fax.

#### (2) Prior Authorization/Medical Review is required for the following condition(s)
All requests for Tecentriq™ (atezolizumab) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

**Breast cancer (triple-negative)**

1. Recurrent, unresectable locally advanced, or metastatic breast cancer, **AND**
2. Attestation of HER2-negative, **AND**
3. Attestation of HR negativity (ER and PR negativity), **AND**
4. Tumor expresses PD-L1 ≥ 1% (PD-L1 stained tumor-infiltrating immune cells [IC] of any intensity covering ≥ 1% of the tumor area) as determined by the VENTANA PD-L1 (SP142) assay, **AND**
5. Being used in combination with Abraxane (albumin-bound paclitaxel)

**Covered Doses**
Up to 840 mg IV on day 1 and 15 of each 4-week cycle

**Coverage Period**
Indefinitely

**ICD-10:**
C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529,
Cutaneous melanoma
1. Disease is unresectable or metastatic, AND
2. Provider attestation patient is BRAF V600 mutation-positive, AND
3. Being used in combination with Cotellic (cobimetinib) and Zelboraf (vemurafenib)

Covered Doses
Up to 840 mg IV every 2 weeks

Coverage Period
Indefinitely

ICD-10:
C43.0, C43.10, C43.111, C43.112, C43.121, C43.122, C43.20-C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59-C43.62, C43.70-C43.72, C43.8, C43.9

Hepatocellular carcinoma
1. Patient has not received prior systemic drug therapy, AND
2. Being used in combination with bevacizumab

Covered Doses
Up to 1200 mg IV every 3 weeks

Coverage Period
Indefinitely

ICD-10:
C22.0, C22.8, C22.9

Non-small cell lung cancer
1. Recurrent, advanced or metastatic disease, AND
2. Either of the following:
   a. First-line treatment and one of the following:
      i. Single agent use, or
      ii. In combination with carboplatin, paclitaxel, and bevacizumab for non-squamous histology, or
      iii. In combination with carboplatin and albumin-bound paclitaxel for non-squamous cell histology
   b. Maintenance treatment and one of the following:
      i. In combination with bevacizumab following first-line therapy with Tecentriq, carboplatin, paclitaxel, and bevacizumab for nonsquamous cell histology, or
      ii. As a single agent following treatment with Tecentriq, carboplatin, and albumin-bound paclitaxel for non-squamous cell histology

Covered Doses
Up to 1200 mg IV every 3 weeks
Small cell lung cancer

- Extensive stage disease (metastatic or inoperable or not eligible for radiation due to advanced stage), AND
- Patient has not received prior systemic treatment for extensive stage disease

Covered doses
Up to 1200 mg IV on day 1 of four 21-day cycles in combination with etoposide and carboplatin, followed by maintenance dose of up to 840 mg every 2 weeks, 1200 mg IV every 3 weeks or 1680 mg every 4 weeks

Coverage period
Indefinitely

ICD-10:
C33, C34.00-C34.02, C34.10-C34.12, C34.2, C34.30-C34.32, C34.80-C34.82, C34.90-C34.92, Z85.118

Urothelial carcinoma

1. Locally advanced, recurrent, or metastatic disease, AND
2. Being used as a single agent, AND
3. One of the following:
   a. Disease progression following a platinum drug, or
   b. First line treatment in patients who are not eligible for any platinum-containing chemo-therapy regardless of PD-L1 status, or
   c. First line treatment in patients who are not eligible for cisplatin treatment, and whose tumors express PD-L1 (PD-L1 stained tumor-infiltrating immune cells [IC] covering ≥ 5% of the tumor area) determined by the VENTANA PD-L1 (SP142) assay

Covered Dose
Up to 1200 mg IV every 3 weeks

Coverage Period
Indefinitely

ICD-10:
C7A.1, C33, C34.00-C34.02, C34.10-C34.12, C34.2, C34.30-C34.32, C34.80-C34.82, C34.90-C34.92, C78.00-C78.02, C79.31, C79.51, C79.52, C61, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0-C67.9, C68.0, D09.0, Z85.5, Z85.59

(3) The following condition(s) DO NOT require Prior Authorization/Preservice
All requests for Tecentriq™ (atezolizumab) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT medically necessary for the following condition(s)
Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information

How Supplied:
- 840 mg (single-use vial)
- 1200 mg (single-use vial)

(6) References
- AHFS®. Available by subscription at http://www.lexi.com

(7) Policy Update

Date of last revision: 4Q2020
Date of next review: 3Q2021
Changes from previous policy version:
- New indication and Section (2): Added coverage for BRAF V600 mutation-positive advanced cutaneous melanoma.
  Rationale: New FDA-approved indication