PRIOR AUTHORIZATION POLICY

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

REVIEW DATE: 03/19/2025; selected revision 03/18/2026

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Tazverik, a methyltransferase *EZH2* inhibitor, is indicated for the following uses:[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).

Tazverik has been withdrawn from the market in March 2026.[5]

Guidelines
Tazverik is addressed in the following guidelines from the National Comprehensive Cancer Network (NCCN):

- **Epithelioid Sarcoma:** NCCN guidelines for soft tissue sarcoma (version 2.2026 – February 17, 2026) recommend Tazverik as a "Preferred" therapy for treatment of metastatic or locally advanced epithelioid sarcoma not eligible for complete resection (category 2A).[2]
- **Follicular Lymphoma:** NCCN guidelines for B-cell lymphomas (version 1.2026 – December 22, 2025) recommend Tazverik as a third-line and subsequent therapy for relapsed or refractory follicular lymphoma, under "Other Recommended Regimen", irrespective of *EZH2* mutation status (category 2A).[3] Tazverik is a "Preferred Regimen" in the second-line, third-line, and subsequent 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.
- **Ovarian Cancer**: NCCN guidelines (version 1.2026 – February 25, 2026) recommend Tazverik as a "Preferred" regimen for small cell carcinoma of the ovary (hypercalcemic type) as recurrence therapy (category 2A)

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

- **Tazverik® (tazemetostat tablets – Epizyme)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indications

1. **Epithelioid Sarcoma.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   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; AND
   D) Patient is continuing therapy with Tazverik.

2. **Follicular Lymphoma.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   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
      Note: Examples of a systemic therapy include one or more of the following agents: bendamustine, Gazyva (obinutuzumab intravenous infusion), rituximab, cyclophosphamide, doxorubicin, vincristine, or lenalidomide.
      ii. According to the prescriber, there are no appropriate alternative therapies; AND
   D) Patient is continuing therapy with Tazverik.

3. **Ovarian Cancer.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has small cell carcinoma of the ovary (hypercalcemic type); AND

C) Patient has tried at least one prior systemic regimen; AND
Note: Examples of a systemic regimen include one or more of the following agents: vinblastine, cisplatin, cyclophosphamide, bleomycin, doxorubicin, etoposide.
D) Patient is continuing therapy with Tazverik.

CONDITIONS NOT COVERED

- **Tazverik® (tazemetostat tablets – Epizyme)**

is(are) considered not medically necessary for ANY other use(s); criteria will be updated as new published data are available.

REFERENCES

1. Tazverik® tablets [prescribing information]. Cambridge, MA: Epizyme; August 2024.
2. The NCCN Soft Tissue Sarcoma Clinical Practice Guidelines in Oncology (version 2.2026 – February 17, 2026). © 2026 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org/. Accessed on February 26, 2026.
3. The NCCN B-Cell Lymphoma Clinical Practice Guidelines in Oncology (version 1.2026 – December 22, 2025). © 2025 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org/. Accessed on February 26, 2026.
4. The Ovarian Cancer Including Fallopian Tube Cancer and Primary Peritoneal Cancer Clinical Practice Guidelines in Oncology (version 1.2026 – February 25, 2026). © 2026 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org/. Accessed on February 26, 2026.
5. Ipsen Press Release. Ipsen voluntarily withdraws Tazverik® (tazemetostat) in follicular lymphoma and epithelioid sarcoma. Available at: https://www.ipsen.com/press-release/ipsen-voluntarily-withdraws-tazverik-tazemetostat-in-follicular-lymphoma-and-epithelioid-sarcoma-3251503/. Accessed on March 17, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Follicular Lymphoma:** To align with guidelines, the requirement that the patient has an EZH2 mutation was removed from the policy.	03/01/2023
Annual Revision	No criteria changes.	03/06/2024
Annual Revision	**Follicular Lymphoma:** A Note with examples of systemic therapy was added.	03/19/2025
Annual Revision	**Ovarian Cancer:** Condition of approval and criteria were added under Other Uses with Supportive Evidence.	03/04/2026
Selected Revision	The overview section was updated to include that Tazverik has been withdrawn from the market in March 2026. **Epithelioid Sarcoma:** The requirement that the patient is continuing therapy with Tazverik was added. **Follicular Lymphoma:** The requirement that the patient is continuing therapy with Tazverik was added. **Ovarian Cancer:** The requirement that the patient is continuing therapy with Tazverik was added.	03/18/2026