Evolent Clinical Guideline 3093 for Tazverik™ (tazemetostat)

Guideline Number:	Applicable Codes	
Evolent_CG_3093		
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Original Date:	**Last Revised Date:**	**Implementation Date:**
February 2020	April 2026	April 2026

TABLE OF CONTENTS

STATEMENT **2**
PURPOSE 2
INDICATIONS **2**
NOTE 2
EPITHELIOID SARCOMA 2
FOLLICULAR LYMPHOMA 3
CONTRAINDICATIONS/WARNINGS **3**
EXCLUSION CRITERIA **3**
CODING AND STANDARDS **4**
CODES 4
APPLICABLE LINES OF BUSINESS 4
POLICY HISTORY **4**
LEGAL AND COMPLIANCE **5**
GUIDELINE APPROVAL 5
Committee *5*
DISCLAIMER 5
REFERENCES **5**

STATEMENT

Purpose

To define and describe the accepted indications for Tazverik (tazemetostat) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

Evolent is responsible for processing all medication requests from network ordering providers. Medications not authorized by Evolent may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

INDICATIONS

Continuation requests for a not-approvable medication shall be exempt from this Evolent policy provided

- The member has not experienced disease progression on the requested medication AND
- The requested medication was used within the last year without a lapse of more than 30 days of having an active authorization AND
- Additional medication(s) are not being added to the continuation request.

NOTE

- On March 9, 2026, Ipsen announced it is voluntarily withdrawing Tazverik (tazemetostat) from all markets and for all of its indications, effective immediately. Ipsen's decision to withdraw is based on emerging data from the ongoing Phase Ib/III SYMPHONY-1 trial (evaluating tazemetostat in combination with lenalidomide plus rituximab (R^2) vs R^2 in follicular lymphoma). The Independent Data Monitoring Committee (IDMC) advised that, based on adverse events of secondary hematologic malignancies, the risks may outweigh potential benefits for patients within this treatment regimen. As a result of these data, Ipsen is withdrawing Tazverik effective immediately, including both for follicular lymphoma (FL) and epithelioid sarcoma (ES).

Epithelioid Sarcoma

- The member is an adult or pediatric member 16 years of age and older with unresectable advanced or metastatic epithelioid sarcoma and the member is not a candidate for surgery and/or radiation, and Tazverik (tazemetostat) is being used as a single agent AND
- The member has contraindications, intolerance, or failure (disease progression) of

anthracycline and/or gemcitabine-based chemotherapy.

Follicular Lymphoma

- Tazverik (tazemetostat) may be used as monotherapy for relapsed or refractory Follicular Lymphoma, as subsequent therapy, regardless of EZH2 mutation status.

CONTRAINDICATIONS/WARNINGS

- None

EXCLUSION CRITERIA

- Tazverik (tazemetostat) is being used after disease progression with the same regimen.
- Concurrent use with other systemic therapies.
- Dosing exceeds single dose limit of Tazverik (tazemetostat) 800 mg.
- Treatment exceeds the maximum limit of 240 (200 mg) tablets/month.
- Investigational use of Tazverik (tazemetostat) with an off-label indication that is not sufficient in evidence or is not generally accepted by the medical community. Sufficient evidence that is not supported by CMS recognized compendia or acceptable peer reviewed literature is defined as any of the following:
    - Whether the clinical characteristics of the patient and the cancer are adequately represented in the published evidence.
    - Whether the administered chemotherapy/biologic therapy/immune therapy/targeted therapy/other oncologic therapy regimen is adequately represented in the published evidence.
    - Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients. Generally, the definitions of Clinically Meaningful outcomes are those recommended by ASCO, e.g., Hazard Ratio of less than 0.80 and the recommended survival benefit for OS and PFS should be at least 3 months.
    - Whether the experimental design, considering the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover).
    - That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.
    - That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
    - That abstracts (including meeting abstracts) without the full article from the approved

peer-reviewed journals lack supporting clinical evidence for determining accepted uses of drugs.

CODING AND STANDARDS

Codes

- J8999 – tazemetostat

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

POLICY HISTORY

Date	Summary
April 2026	• Added voluntary withdrawal verbiage to indication section • Updated references
May 2025	• Converted to new Evolent guideline template • This guideline replaces UM ONC_1385 Tazverik (tazemetostat) • Updated references
May 2024	• Updated NCH verbiage to Evolent

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

REFERENCES

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