Atezolizumab and Hyaluronidase-tqjs (Tecentriq Hybreza™)

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

POLICY

INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

- Non-Small Cell Lung Cancer (NSCLC)
  - Tecentriq Hybreza, as monotherapy, is indicated as adjuvant treatment following resection and platinum-based chemotherapy for adult patients with stage II to IIIA NSCLC whose tumors have PD-L1 expression on ≥ 1% of tumor cells, as determined by an FDA-approved test.
  - Tecentriq Hybreza, as monotherapy, is indicated for the first-line treatment of adult patients with metastatic NSCLC whose tumors have high PD-L1 expression (PD-L1 stained ≥ 50% of tumor cells [TC ≥ 50%] or PD-L1 stained tumor-infiltrating immune cells [IC] covering ≥ 10% of the tumor area [IC ≥ 10%]), as determined by an FDA-approved test, with no EGFR or ALK genomic tumor aberrations.
  - Tecentriq Hybreza, in combination with bevacizumab, paclitaxel, and carboplatin, is indicated for the first-line treatment, of adult patients with metastatic non-squamous NSCLC with no EGFR or ALK genomic tumor aberrations.
  - Tecentriq Hybreza, in combination with paclitaxel protein-bound and carboplatin, is indicated for the first-line treatment of adult patients with metastatic non-squamous NSCLC with no EGFR or ALK genomic tumor aberrations.
  - Tecentriq Hybreza as monotherapy, is indicated for the treatment of adult patients with metastatic NSCLC who have disease progression during or following platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for NSCLC harboring these aberrations prior to receiving Tecentriq Hybreza.
- Small Cell Lung Cancer (SCLC)
  - Tecentriq Hybreza, in combination with carboplatin and etoposide, is indicated for the first-line treatment of adult patients with extensive-stage small cell lung cancer (ES-SCLC).
  - Tecentriq Hybreza, in combination with lurbinectedin, is indicated for the maintenance treatment of adult patients with ES-SCLC whose disease has not progressed after first-line induction therapy with Tecentriq Hybreza or intravenous atezolizumab, carboplatin and etoposide.
- Tecentriq Hybreza, in combination with bevacizumab, is indicated for the treatment of adult patients with unresectable or metastatic hepatocellular carcinoma (HCC) who have not received prior systemic therapy.
- Tecentriq Hybreza, in combination with cobimetinib and vemurafenib, is indicated for the treatment of adult patients with BRAF V600 mutation-positive unresectable or metastatic melanoma as determined by an FDA-approved test.

- Tecentriq Hybreza, as monotherapy, is indicated for the treatment of adult and pediatric patients (12 years of age or older who weigh 40 kg or greater) with unresectable or metastatic alveolar soft part sarcoma (ASPS).
- Tecentriq Hybreza, as monotherapy, is indicated as adjuvant treatment of adult patients with muscle invasive bladder cancer (MIBC) after cystectomy who have circulating tumor DNA molecular residual disease (ctDNA MRD) as determined by an FDA-authorized test.

Compendial Uses

- Non-small cell lung cancer (NSCLC)
- Small cell lung cancer (SCLC)
- Hepatocellular carcinoma (HCC)
- Mesothelioma
- Melanoma
- Alveolar soft part sarcoma (ASPS)
- Cervical cancer
- Colon cancer
- Thymic carcinoma
- Histologic (Richter) transformation to diffuse large B-cell lymphoma
- Small bowel adenocarcinoma
- Rectal cancer

DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:

- Test results confirming PD-L1 tumor expression (where applicable)
- Test results confirming tumor is positive for BRAF V600 mutation (where applicable)
- Test results confirming the absence of EGFR exon 19 deletion, L858R mutations, and ALK, RET, or ROS1 gene fusions (where applicable)
- Test results confirming microsatellite instability-high (MSI-H), mismatch repair deficient (dMMR), or polymerase epsilon/delta (POLE/POLD1) with ultra-hypermutated tumor mutational burden [TMB] (greater than 50 mutations/megabase [mut/Mb]) (where applicable)
- Test results confirming circulating tumor DNA molecular residual disease (ctDNA MRD) (where applicable)

EXCLUSIONS

Coverage will not be provided for members who have experienced disease progression while on PD-1 or PD-L1 inhibitor therapy.

COVERAGE CRITERIA

Non-Small Cell Lung Cancer (NSCLC)

- Authorization of 6 months may be granted for treatment of recurrent, advanced or metastatic non-small cell lung cancer when there are no EGFR exon 19 deletions or L858R mutations or ALK , RET, or

ROS1 gene fusions (unless testing is not feasible due to insufficient tissue) and any of the following criteria are met:
  - The requested medication will be used as continued maintenance therapy as a single agent or in combination with bevacizumab.
  - The requested medication will be used as first line or subsequent therapy in combination with chemotherapy with or without bevacizumab.
  - The requested medication will be used as first line or subsequent therapy as a single agent.
- Authorization of 6 months may be granted for treatment of stage IB to IIIB non-small cell lung cancer that is PD-L1 positive as single agent adjuvant therapy when there are no EGFR exon 19 deletions or L858R mutations or ALK , RET, or ROS1 gene fusions (unless testing is not feasible due to insufficient tissue).

Small Cell Lung Cancer (SCLC)

Authorization of 6 months may be granted for treatment of SCLC when the requested medication will be used in combination with etoposide and carboplatin, followed by maintenance therapy as a single agent or with lurbinectedin, for extensive-stage disease.

Hepatocellular Carcinoma (HCC)

Authorization of 6 months may be granted in combination with bevacizumab for the treatment of progressive, unresectable, or metastatic hepatocellular carcinoma (HCC).

Melanoma

Authorization of 6 months may be granted for subsequent treatment of BRAF V600 mutation-positive unresectable or metastatic melanoma when the requested medication will be used in combination with cobimetinib (Cotellic) and vemurafenib (Zelboraf).

Alveolar Soft Part Sarcoma (ASPS)

Authorization of 6 months may be granted for the treatment of ASPS when used as a single agent.

Mesothelioma

Authorization of 6 months may be granted for the subsequent treatment of peritoneal mesothelioma, pericardial mesothelioma, or tunica vaginalis testis mesothelioma when used in combination with bevacizumab.

Cervical Cancer

Authorization of 6 months may be granted for the treatment of cervical cancer when either of the following criteria is met:

- The member has persistent, recurrent or metastatic small cell neuroendocrine carcinoma of the cervix (NECC) when used in combination with etoposide and either cisplatin or carboplatin (may be used as a single agent for maintenance).
- The member has recurrent or metastatic adenocarcinoma, adenosquamous, or squamous cell carcinoma and the requested medication will be used in combination with bevacizumab, paclitaxel, and either cisplatin or carboplatin (may be used in combination with bevacizumab for maintenance).

Colon Cancer

Authorization of 6 months may be granted for treatment of colon cancer when the member's disease is confirmed to be deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) or polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype (TMB >50 mut/Mb) and either of the following criteria are met:

- The requested medication will be used in combination with FOLFOX or CAPEOX regimens (followed by single agent maintenance) for adjuvant treatment of stage IIC-III or metastatic disease.
- The requested medication will be used as a single agent for treatment of locally unresectable, medically inoperable, advanced, or metastatic disease.

Authorization of up to 6 months may be granted for neoadjuvant treatment of colon cancer that is confirmed to be deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) or polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype (TMB >50 mut/Mb) when the requested medication will be used as a single agent.

Thymic Carcinoma

Authorization of 6 months may be granted for first-line treatment or postoperative systemic therapy for thymic carcinoma in combination with carboplatin and paclitaxel followed by single agent maintenance.

Histologic (Richter) Transformation to Diffuse Large B-Cell Lymphoma

Authorization of 6 months may be granted for the treatment of Histologic (Richter) transformation to diffuse large B-cell lymphoma (DLBCL) when the requested medication will be used in combination with venetoclax and obinutuzumab.

Small Bowel Adenocarcinoma

Authorization of 6 months may be granted for the treatment of small bowel adenocarcinoma when the disease is confirmed to be deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) or polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype (TMB >50 mut/Mb) in any of the following settings:

- As adjuvant therapy when used combination with FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CAPEOX (capecitabine and oxaliplatin) regimens, followed by single agent maintenance
- As neoadjuvant therapy for resectable disease, when used as a single agent
- As treatment for locally unresectable, medically inoperable, advanced, or metastatic disease, when used as a single agent

Muscle Invasive Bladder Cancer (MIBC)

Authorization of 6 months may be granted for adjuvant treatment of MIBC, as a single agent, when the member has undergone cystectomy and is positive for circulating tumor DNA molecular residual disease (ctDNA MRD).

Rectal Cancer

Authorization of 6 months may be granted for treatment of recurrent, advanced, or metastatic rectal cancer that is confirmed to be deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) or polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype (TMB >50 mut/Mb) when the requested medication will be used as a single agent.

Authorization of up to 6 months may be granted for neoadjuvant treatment of rectal cancer that is confirmed to be deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) or polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype (TMB >50 mut/Mb) when the requested medication will be used as a single agent.

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CONTINUATION OF THERAPY

Adjuvant treatment of Hepatocellular Carcinoma (HCC), Non-Small Cell Lung Cancer (NSCLC), Colon Cancer, Small Bowel Adenocarcinoma, and Muscle Invasive Bladder Cancer (MIBC)

Authorization of 6 months may be granted (up to 12 months total) for continued treatment in members requesting reauthorization of adjuvant therapy of hepatocellular carcinoma, non-small cell lung cancer, colon cancer, small bowel adenocarcinoma, or muscle invasive bladder cancer who have not experienced disease recurrence or unacceptable toxicity.

Neoadjuvant treatment of Colon Cancer and Rectal Cancer

Authorization of up to a total of 6 months may be granted for continued treatment in members requesting reauthorization for neoadjuvant treatment of colon cancer or rectal cancer who have not experienced disease progression or unacceptable toxicity.

Thymic Carcinoma

Authorization of 6 months may be granted (up to 24 months total) for continued treatment in members requesting reauthorization for treatment of thymic carcinoma who have not experienced disease progression or unacceptable toxicity.

All other indications

Authorization of 6 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

MEDICATION QUANTITY LIMITS

Drug Name	Diagnosis	Maximum Dosing Regimen
Tecentriq Hybreza (Atezolizumab-Hyaluronidase-tqjs)	Alveolar Soft Part Sarcoma (ASPS)	Route of Administration: Subcutaneous 1875/30,000mg-units every 3 weeks
Tecentriq Hybreza (Atezolizumab-Hyaluronidase-tqjs)	Cervical Cancer	Route of Administration: Subcutaneous 1875/30,000mg-units every 3 weeks
Tecentriq Hybreza (Atezolizumab-Hyaluronidase-tqjs)	Chronic Lymphocytic Leukemia	Route of Administration: Subcutaneous 1875/30,000mg-units every 3 weeks
Tecentriq Hybreza (Atezolizumab-Hyaluronidase-tqjs)	Colon Cancer	Route of Administration: Subcutaneous 1875/30,000mg-units every 3 weeks
Tecentriq Hybreza (Atezolizumab-Hyaluronidase-tqjs)	Hepatocellular Carcinoma	Route of Administration: Subcutaneous 1875/30,000mg-units every 3 weeks

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Tecentriq Hybreza (Atezolizumab-Hyaluronidase-tqjs)	Malignant Peritoneal Mesothelioma, Pericardial Mesothelioma, or Tunica Vaginalis Testis Mesothelioma	Route of Administration: Subcutaneous 1875/30,000mg-units every 3 weeks
Tecentriq Hybreza (Atezolizumab-Hyaluronidase-tqjs)	Melanoma	Route of Administration: Subcutaneous 1875/30,000mg-units every 3 weeks
Tecentriq Hybreza (Atezolizumab-Hyaluronidase-tqjs)	Non-Small Cell Lung Cancer or Small Cell Lung Cancer	Route of Administration: Subcutaneous 1875/30,000mg-units every 3 weeks
Tecentriq Hybreza (Atezolizumab-Hyaluronidase-tqjs)	Small Bowel Adenocarcinoma	Route of Administration: Subcutaneous 1875/30,000mg-units every 3 weeks
Tecentriq Hybreza (Atezolizumab-Hyaluronidase-tqjs)	Thymic Carcinoma	Route of Administration: Subcutaneous 1875/30,000mg-units every 3 weeks

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

1. Tecentriq Hybreza [package insert]. South San Francisco, CA: Genentech, Inc.; May 2026.
2. The NCCN Drugs & Biologics Compendium® © 2026 National Comprehensive Cancer Network, Inc. Available at: https://www.nccn.org. Accessed June 1, 2026.

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