Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	X	X	X	X

Polivy (polatuzumab vedotin-piiq)

Override(s)	Approval Duration
Prior Authorization	1 year

Medications
Polivy (polatuzumab vedotin-piiq)

APPROVAL CRITERIA

Requests for Polivy (polatuzumab vedotin-piiq) may be approved if the following criteria are met:

I. Individual has a diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL); **AND**
II. Individual is using in combination with bendamustine and a rituximab product; **AND**
III. Individual has received at least two prior therapies.

Requests for Polivy (polatuzumab vedotin-piiq) may not be approved when the above criteria are not met and for all other indications.

State Specific Mandates		
State name	Date effective	Mandate details (including specific bill if applicable)
N/A	N/A	N/A

This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.
CRX-ALL-0412-19

Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	X	X	X	X

Key References:

1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2019. URL: http://www.clinicalpharmacology.com. Updated periodically.
2. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm.
3. DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.
4. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2019; Updated periodically.

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