

**Clinical Policy: Talazoparib (Talzenna)**

Reference Number: CP.PHAR.409

Effective Date: 03.01.19

Last Review Date: 02.26

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

**Description**

Talazoparib (Talzenna<sup>®</sup>) is a poly (ADP-ribose) polymerase (PARP) inhibitor.

**FDA Approved Indication(s)**

Talzenna is indicated for the treatment of adult patients with

- Deleterious or suspected deleterious germline *BRCA*-mutated (gBRCAm) human epidermal growth factor receptor 2 (HER2)-negative locally advanced or metastatic breast cancer, as a single agent. Select patients for therapy based on an FDA-approved companion diagnostic for Talzenna.
- Homologous recombination repair (HRR) gene-mutated metastatic castration-resistant prostate cancer (mCRPC), in combination with enzalutamide.

**Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Talzenna is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria****A. Breast Cancer** (must meet all):

1. Diagnosis of recurrent, locally advanced, or metastatic breast cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age  $\geq$  18 years;
4. For brand Talzenna requests, member must use generic talazoparib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Prescribed as a single agent;
6. Documentation of deleterious or suspected deleterious *BRCA* 1/2 mutation;
7. Member has not previously received a PARP inhibitor (e.g., Lynparza<sup>®</sup>, Rubraca<sup>®</sup>, Zejula<sup>®</sup>, Akeega<sup>®</sup>);
8. Request does not exceed health-plan approved quantity limit;
9. Request meets one of the following (a or b):\*
  - a. Dose does not exceed both of the following (i and ii):
    - i. 1 mg per day;
    - ii. 1 capsule per day;
  - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

*\*Prescribed regimen must be FDA-approved or recommended by NCCN*

**Approval duration:**

**Medicaid/HIM** – 12 months

**Commercial** – 12 months or duration of request, whichever is less

**B. Prostate Cancer** (must meet all):

1. Diagnosis of metastatic CRPC, as evidenced by disease progression despite bilateral orchiectomy or other androgen deprivation therapy (ADT) (*see Appendix D*);
2. Prescribed by or in consultation with an oncologist or urologist;
3. Age  $\geq$  18 years;
4. For brand Talzenna requests, member must use generic talazoparib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Documentation of a HRR gene mutation;
6. Prescribed concurrently with Xtandi<sup>®</sup>;
7. Prescribed concurrently with systemic ADT or member has had a bilateral orchiectomy (*see Appendix D*);
8. Member has not previously received a PARP inhibitor (e.g., Lynparza, Rubraca, Zejula, Akeega);
9. Request does not exceed health-plan approved quantity limit;
10. Request meets one of the following (a or b):\*
  - a. Dose does not exceed both of the following (i and ii):
    - i. 0.5 mg per day;
    - ii. 1 capsule per day;
  - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

*\*Prescribed regimen must be FDA-approved or recommended by NCCN*

**Approval duration:**

**Medicaid/HIM** – 12 months

**Commercial** – 12 months or duration of request, whichever is less

**C. Other diagnoses/indications** (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

## II. Continued Therapy

### A. All Indications in Section I (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Talzenna for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For brand Talzenna requests, member must use generic talazoparib, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. Request does not exceed health-plan approved quantity limit;
5. If request is for a dose increase, request meets one of the following (a, b, or c):\*
  - a. For breast cancer: New does not exceed both of the following (i and ii):
    - i. 1 mg per day;
    - ii. 1 capsule per day;
  - b. For mCRPC: New dose does not exceed both of the following (i and ii):
    - i. 0.5 mg per day;
    - ii. 1 capsule per day;
  - c. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

\*Prescribed regimen must be FDA-approved or recommended by NCCN

### Approval duration:

**Medicaid/HIM** – 12 months

**Commercial** – 12 months or duration of request, whichever is less

### B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

ADP: adenosine diphosphate

ADT: androgen deprivation therapy

BRCA: breast cancer gene

gBRCAm: mutations in the germline

BRCA genes

FDA: Food and Drug Administration

GnRH: gonadotropin-releasing hormone

HER2: human epidermal growth factor  
receptor 2

HR: hormone receptor

HRR: homologous recombination repair

mCRPC: metastatic castration-resistant  
prostate cancer

NCCN: National Comprehensive Cancer  
Network

PARP: poly (ADP-ribose) polymerase

*Appendix B; Therapeutic Alternatives*

Not applicable

*Appendix C: Contraindications/Boxed Warnings*

None reported

*Appendix D: General Information*

- The FDA approved indication for talazoparib includes using the diagnostic tool BRACAnalysis CDx<sup>®</sup> by Myriad Genetic Laboratories. It is available at <http://www.fda.gov/companiondiagnostics>.
- There is insufficient data regarding the use of consecutive PARP inhibitors. Most PARP inhibitor pivotal trials excluded prior PARP inhibitor use, the NCCN does not make any explicit recommendations (other than for ovarian cancer, where they state data is limited), and there are no randomized controlled trials evaluating such use.
- NCCN recommended use for breast cancer: Single agent therapy (preferred regimen) for patients with no response to preoperative systemic therapy, or recurrent unresectable (local or regional) or:
  - stage IV (M1) human epidermal growth factor receptor 2 (HER2)-negative, BRCA 1/2-germline mutated disease that is hormone receptor-positive with visceral crisis or endocrine therapy refractory
  - stage IV (M1) triple-negative breast cancer (TNBC), BRCA 1/2- germline mutate disease:
    - as first-line therapy if PD-L1 CPS <10
    - as second-line therapy
- Examples of ADT include:
  - Bilateral orchiectomy (surgical castration)
  - Luteinizing hormone-releasing hormone (LHRH) given with or without an anti-androgen

- LHRH (or GnRH) agonists: Zoladex<sup>®</sup> (goserelin), Supprelin<sup>®</sup> (histrelin), leuprolide (Lupron Depot<sup>®</sup>, Eligard<sup>®</sup>, Camcevi<sup>™</sup>, Camcevi ETM<sup>®</sup>), and Trelstar<sup>®</sup> (triptorelin)
- Anti-androgens: bicalutamide (Casodex<sup>®</sup>), Eulexin<sup>®</sup> (flutamide), nilutamide (Nilandron<sup>®</sup>)
- LHRH antagonist: Firmagon<sup>®</sup> (degarelix), Orgovyx<sup>®</sup> (relugolix)

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Breast cancer	1 mg PO QD  For patients with moderate renal impairment (CrCl 30 – 59 mL/min): 0.75 mg PO QD  For patients with severe renal impairment (CrCl 15 – 29 mL/min): 0.5 mg PO QD	1 mg/day
mCRPC	0.5 mg PO QD in combination with enzalutamide  For patients with moderate renal impairment (CrCl 30 – 59 mL/min): 0.35 mg PO QD  For patients with severe renal impairment (CrCl 15 – 29 mL/min): 0.25 mg PO QD	0.5 mg/day

**VI. Product Availability**

- Hard hypromellose capsules: 0.1 mg, 0.25 mg, 0.35 mg, 0.5 mg, 0.75 mg, 1 mg
- Soft gelatin capsules: 0.1 mg, 0.25 mg, 0.35 mg, 0.5 mg, 0.75 mg, 1 mg

**VII. References**

1. Talzenna (Hard Capsules) Prescribing Information. New York NY: Pfizer; June 2025. Available at: <https://labeling.pfizer.com/ShowLabeling.aspx?id=11046>. Accessed November 12, 2025.
2. Talzenna (Soft Gelatin) Prescribing Information. New York NY: Pfizer; June 2025. Available at: <https://labeling.pfizer.com/ShowLabeling.aspx?id=20582> Accessed November 12, 2025.
3. Litton JK, Rugo HS, Ettl J, et al. Talazoparib in patients with advanced breast cancer and a germline BRCA mutation. *N Engl J Med*. 2018; 379:753-763.
4. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: [http://www.nccn.org/professionals/drug\\_compendium](http://www.nccn.org/professionals/drug_compendium). Accessed November 12, 2025.
5. National Comprehensive Cancer Network. Breast Cancer Version 5.2025. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/breast.pdf](https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf). Accessed November 12, 2025.
6. National Comprehensive Cancer Network. Prostate Cancer Version 3.2026. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/prostate.pdf](https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf). Accessed November 12, 2025.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: no significant changes; RT4: added new strengths (0.5 mg and 0.75 mg) and removed dose optimization language for renal impairment; references reviewed and updated.	10.04.21	02.22
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	01.20.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.23.22	
1Q 2023 annual review: no significant changes; revised “medical justification” to “member must use” language per updated template; updated Appendix D; references reviewed and updated.	10.17.22	02.23
RT4: new indication of mCRPC added in addition to new strength capsules.	07.11.23	
1Q 2024 annual review: for prostate cancer, added “member will use a gonadotropin-releasing hormone (GnRH) analog concurrently or has had a bilateral orchiectomy” per NCCN compendium; for breast cancer, added “prescribed as a single agent” to align with FDA indication and NCCN compendium; updated Appendix D to align with current NCCN compendium; references reviewed and updated.	10.24.23	02.24
RT4: added new soft gelatin capsule formulation; for continued therapy, changed maximum dosing criteria from “does not exceed both of the following” to “does not exceed any of the following” to allow variability in maximum daily dose reduction per prescriber information.	03.25.24	
1Q 2025 annual review: for breast cancer, removed “documentation of HER2-negative disease” as use for HER2-positive disease is supported by NCCN compendium and guideline; updated Appendix D to align with current NCCN compendium; references reviewed and updated.	11.18.24	02.25
1Q 2026 annual review: for all indications, added requirement that request does not exceed health-plan approved quantity limit, revised quantity limit to maximum dose per day <i>and</i> 1 capsule per day, extended Medicaid and HIM initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.	11.12.25	02.26

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in

developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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