

Clinical Policy: Obinutuzumab (Gazyva)

Reference Number: CP.PHAR.305

Effective Date: 02.01.17

Last Review Date: 11.18

Line of Business: Medicaid, HIM-Medical Benefit

[Coding Implications](#)

[Revision Log](#)

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

Description

Obinutuzumab (Gazyva[®]) is a CD20-directed cytolytic antibody.

FDA Approved Indication(s)

Gazyva is indicated:

- In combination with chlorambucil, for the treatment of patients with previously untreated chronic lymphocytic leukemia (CLL)
- In combination with bendamustine followed by Gazyva monotherapy, for the treatment of patients with follicular lymphoma (FL) who relapsed after, or are refractory to, a rituximab-containing regimen
- In combination with chemotherapy followed by Gazyva monotherapy in patients achieving at least a partial remission, for the treatment of adult patients with previously untreated stage II bulky, III or IV follicular lymphoma

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[®] that Gazyva is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (must meet all):

1. Diagnosis of CLL (i.e., small lymphocytic lymphoma [SLL]);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age \geq 18 years;
4. Request meets one of the following (a or b):
 - a. After initial loading doses, dose does not exceed 1,000 mg per 28-day cycle;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

B. Follicular Lymphoma (must meet all):

1. Diagnosis of FL;
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age \geq 18 years;

4. Request meets one of the following (a or b):
 - a. After initial loading doses, dose does not exceed 1,000 mg per 28-day cycle;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

C. Marginal Zone Lymphoma (off-label) (must meet all):

1. Diagnosis of marginal zone lymphoma (i.e., gastric or nongastric MALT lymphoma, nodal marginal zone lymphoma, or splenic marginal zone lymphoma);
2. Prescribed by or in consultation with an oncologist or hematologist;
3. Age \geq 18 years;
4. Member has used appropriate prior therapy (*see Appendix B for examples*);
5. Request meets one of the following:
 - a. Dose does not exceed the maximum indicated in section V;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

D. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 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 Gazyva for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):
 - a. After initial loading doses, new dose does not exceed 1,000 mg per 28-day cycle;
 - b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 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 – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CLL: chronic lymphocytic leukemia
 FDA: Food and Drug Administration
 FL: follicular lymphoma
 MALT: mucosa-associated lymphoid tissue

NCCN: National Comprehensive Cancer Network
 NHL: non-Hodgkin lymphoma
 SLL: small lymphocytic lymphoma

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

| Examples of First-Line Therapy for Marginal Zone Lymphoma | Dosing Regimen | Dose Limit/ Maximum Dose |
|--|----------------|--------------------------|
| Treanda [®] , Bendeka [®] (bendamustine) + Rituxan [®] (rituximab) | Varies | Varies |
| RCHOP [Rituxan [®] (rituximab), cyclophosphamide, doxorubicin, vincristine (Vincasar PFS [®]), prednisone] | Varies | Varies |
| RCVP [Rituxan [®] (rituximab), cyclophosphamide, vincristine (Vincasar PFS [®]), prednisone] | Varies | Varies |
| Rituxan [®] (rituximab) (375 mg/m ² weekly for 4 doses) (preferred for SMZL) | Varies | Varies |
| Leukeran [®] (chlorambucil) + Rituxan [®] (rituximab) | Varies | Varies |
| cyclophosphamide + Rituxan [®] (rituximab) | Varies | Varies |

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): patients with known hypersensitivity reactions (e.g., anaphylaxis) to obinutuzumab or any of the excipients, including serum sickness with prior obinutuzumab use
- Boxed warning(s): hepatitis B virus reactivation and progressive multifocal leukoencephalopathy

V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|------------|--|--------------|
| CLL/SLL | 100 mg IV on day 1, 900 mg IV on day 2 of cycle 1, then 1,000 mg IV on days 8 and 15 of cycle 1; begin the next cycle of therapy on day 29. For cycles 2 to 6, give obinutuzumab 1,000 mg IV on day 1 repeated every 28 days. Administer obinutuzumab in combination with chlorambucil (0.5 mg/kg orally on day 1 and 15) in cycles 1 to 6. | See regimen |
| FL | <p>1,000 mg IV on day 1, 8 and 15 of Cycle1, 1,000 mg on day 1 of Cycles 2-6 or Cycles 2-8, and then 1,000 mg every 2 months for up to 2 years.</p> <p>For patients with relapsed or refractory FL, administer Gazyva in combination with bendamustine in six 28-day cycles. Patients who achieve stable disease, complete response, or partial response to the initial 6 cycles should continue on Gazyva 1,000 mg as monotherapy for up to two years.</p> <p>For patients with previously untreated FL, administer Gazyva with one of the following chemotherapy regimens:</p> <ul style="list-style-type: none"> • Six 28-day cycles in combination with bendamustine • Six 21-day cycles in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone), followed by 2 additional 21-day cycles of Gazyva alone • Eight 21-day cycles in combination with CVP (cyclophosphamide, vincristine, prednisone) <p>Patients with previously untreated FL who achieve a complete response or partial response to the initial 6 or 8 cycles should continue on Gazyva 1,000 mg as monotherapy for up to two years.</p> | See regimen |

VI. Product Availability

Single-dose vial: 1,000 mg/40 mL (25 mg/mL)

VII. References

1. Gazyva Prescribing Information. South San Francisco, CA: Genentech, Inc.; November 2017. Available at: <https://www.gazyva.com/>. Accessed July 11, 2018.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 16, 2018.
3. National Comprehensive Cancer Network. Chronic lymphocytic leukemia/small lymphocytic lymphoma Version 5.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cll.pdf. Accessed July 16, 2018.
4. National Comprehensive Cancer Network. B-cell lymphomas Version 4.2018. Available at: https://www.nccn.org/professionals/physician_gls/pdf/b-cell.pdf. Accessed July 16, 2018.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| HCPCS Codes | Description |
|-------------|--------------------------------|
| J9301 | Injection, obinutuzumab, 10 mg |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|----------|-------------------|
| Policy split from CP.PHAR.182 Excellus Oncology. | 01.01.17 | 02.17 |
| Age and dosing added Safety information removed. NCCN recommended uses added separately. HCPCS code updated. | 09.05.17 | 11.17 |
| 4Q 2018 annual review: HIM-Medical Benefit added; summarized NCCN and FDA-approved uses for improved clarity; added specialist involvement in care; separated FL and off-label MZL into individual criteria sets; removed primary cutaneous B-cell lymphomas as a covered off-label indication (not listed in the NCCN compendium for Gazyva); updated continued therapy section to include language for continuity of care; references reviewed and updated. | 07.16.18 | 11.18 |

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.

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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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