Clinical Policy: Obinutuzumab (Gazyva)

Reference Number: CP.PHAR.305
Effective Date: 02.01.17
Last Review Date: 11.17
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Obinutuzumab injection (Gazyva®) is a CD20-directed cytolytic antibody.

FDA Approved Indication(s)
- Chronic lymphocytic leukemia
  - Gazyva, in combination with chlorambucil, is indicated for the treatment of patients with previously untreated chronic lymphocytic leukemia (CLL).
- Follicular lymphoma
  - Gazyva, in combination with bendamustine followed by Gazyva monotherapy, is indicated for the treatment of patients with follicular lymphoma (FL) who relapsed after, or are refractory to, a rituximab-containing regimen.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) 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. Non-Hodgkin Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (must meet all)**:**

1. Diagnosis of chronic lymphocytic leukemia (CLL) (i.e., small lymphocytic lymphoma [SLL]);
2. Age ≥ 18 years;
3. Meets (a or b):
   a. FDA approved use:
      i. In combination with chlorambucil in previously untreated (CLL)/SLL;
   b. NCCN recommended use (i or ii):
      i. First-line therapy for CLL/SLL in combination with chlorambucil for disease without del(17p)/TP53 mutation if ≥ 65 years of age, if younger with significant comorbidities, or if frail and unable to tolerate purine analogs;
      ii. Single agent therapy for relapsed or refractory CLL/SLL without del(17p)/TP53 mutation;
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. Non-Hodgkin B-Cell Lymphomas (must meet all)**:**

1. Age ≥ 18 years;
2. One of the following diagnoses:
   a. Follicular lymphoma (FL):
      i. Meets (a or b):
         a) FDA approved use:
            1) In combination with bendamustine followed by Gazyva monotherapy for FL that has relapsed after, or is refractory to, a rituximab-containing regimen;
         b) NCCN recommended use:
            1) First-line therapy for stage I (bulky), contiguous stage II (bulky), non-contiguous stage II disease, or stage III or IV disease in combination with (1, 2 or 3):
               a. CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) regimen;
               b. CVP (cyclophosphamide, vincristine, and prednisone) regimen;
               c. Bendamustine;
            2) Second-line or subsequent therapy for refractory or progressive disease in combination with bendamustine;
            3) Maintenance therapy (1 or 2):
               a. As first-line consolidation or extended dosing;
               b. As second-line consolidation or extended dosing if refractory to rituximab;
   b. A marginal zone lymphoma (i.e., gastric or nongastric MALT lymphoma, nodal marginal zone lymphoma, or splenic marginal zone lymphoma):
      i. NCCN recommended use (a, b or c):
         a) Second-line or subsequent therapy for recurrent or progressive disease in combination with bendamustine;
         b) Maintenance therapy as second-line consolidation or extended dosing in rituximab refractory disease treated with obinutuzumab and bendamustine regimen for recurrent disease;
         c) Second-line or subsequent therapy for refractory or progressive disease in combination with rituximab or obinutuzumab (nongastric MALT lymphoma only);
3. Request meets one of the following (a or b):
   a. FL: 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. Non-Hodgkin Primary Cutaneous B-Cell Lymphomas (must meet all)**:**
1. Diagnosis of primary cutaneous B-cell lymphoma;
2. Age ≥ 18 years of age;
3. NCCN recommended use (a or b):
   a. For primary cutaneous marginal zone or follicle center lymphoma as therapy for very extensive or refractory generalized T3 cutaneous disease or as second-line or subsequent therapy with bendamustine for refractory or progressive generalized extracutaneous disease;
   b. Maintenance therapy for rituximab-refractory disease as second-line extended dosing;
4. 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 CP.PHAR.57 for specialty if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy (e.g., no disease progression or unacceptable toxicity);
3. If request is for a dose increase, request meets one of the following (a or b):
   a. CLL/SLL and FL: 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 CP.PHAR.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 policy – CP.PHAR.57 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
PTCL: peripheral T-cell lymphoma
SLL: small lymphocytic lymphoma

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CLL/SLL	Cycles 1 through 6 in combination with chlorambucil (each cycle is 28 days): • Cycle 1: Day 1 - 100 mg; day 2 - 900 mg; day 8 - 1,000 mg; day 15 - 1,000 • Cycles 2-6: 1,000 mg every 28 days	See regimen
FL	Cycles 1 through 6 in combination with bendamustine (each cycle is 28 days): • Cycle 1: Day 1 - 1,000 mg; day 8 - 1,000 mg; day 15 - 1,000 • Cycles 2-6: 1,000 mg every 28 days Then as monotherapy: 1,000 mg every 2 months for 2 years	See regimen

VI. Product Availability

Gazyva 1000 mg/40 mL (25 mg/mL) single-dose vial preservative-free solution

VII. References

1. Gazyva Prescribing Information. South San Francisco, CA: Genentech, Inc.; February 2016. Available at: https://www.gene.com/download/pdf/gazyva_prescribing.pdf. Accessed August 2017.
2. Obinituzumab. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at nccn.org. Accessed August 2017.
3. Chronic lymphocytic leukemia/small lymphocytic lymphoma (Version 2.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed August 2017.
4. B-cell lymphomas (Version 3.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed August 2017.
5. Peripheral T-cell lymphoma (Version 2.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed August 2017.

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

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.