Evolent Clinical Guideline 3032 for Brukinsa™ (zanubrutinib)

Guideline Number:	Applicable Codes	
Evolent_CG_3032		
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Original Date:	**Last Revised Date:**	**Implementation Date:**
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STATEMENT

Purpose

To define and describe the accepted indications for Brukinsa (zanubrutinib) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

Evolent is responsible for processing all medication requests from network ordering providers. Medications not authorized by Evolent may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

INDICATIONS

Continuation requests for a not-approvable medication shall be exempt from this Evolent policy provided

- The member has not experienced disease progression on the requested medication AND
- The requested medication was used within the last year without a lapse of more than 30 days of having an active authorization AND
- Additional medication(s) are not being added to the continuation request.

B-Cell Lymphomas (Mantle Cell Lymphoma, Nodal/Extra-nodal/Splenic Marginal Zone Lymphoma)

- The member has mantle cell lymphoma or nodal/extra-nodal/splenic marginal zone lymphoma AND Brukinsa (zanubrutinib) will be used as monotherapy in members with disease progression on at least one prior treatment, including an anti-CD20 agent (e.g., rituximab/rituximab biosimilar).

Chronic Lymphocytic Leukemia (CLL)/ Small Lymphocytic Lymphoma (SLL)

- Brukinsa (zanubrutinib) may be used as monotherapy in adult members with CLL/SLL for initial or subsequent line therapy.
- Brukinsa (zanubrutinib) may be used in combination with Tevimbra (tislelizumab-jsgr) in adult members with CLL/SLL for the histologic (Richter) transformation to diffuse large B-cell lymphoma (clonally related or unknown clonal status). The members have the del(17p)/TP53 mutation OR are chemotherapy refractory or unable to receive chemoimmunotherapy.

Follicular Lymphoma (FL)

- Brukinsa (zanubrutinib) may be used with Gazyva (obinutuzumab) in members with relapsed or refractory follicular lymphoma who have failed on two or more lines of

systemic therapy.

Waldenström's Macroglobulinemia (WM)

- The member has a diagnosis of Waldenström's Macroglobulinemia (WM) and Brukinsa (zanubrutinib) will be used as monotherapy as initial therapy or therapy for relapsed disease.

CONTRAINDICATIONS/WARNINGS

- None

EXCLUSION CRITERIA

- Brukinsa (zanubrutinib) is being used after disease progression with the same regimen or prior disease progression on a BTK inhibitor (e.g., ibrutinib, acalabrutinib).
- Dosing exceeds single dose limit of Brukinsa (zanubrutinib) 320 mg.
- Treatment exceeds the maximum limit of 120 (80 mg) capsules/month or 60 (160 mg) tablets/month.
- Investigational use of Brukinsa (zanubrutinib) with an off-label indication that is not sufficient in evidence or is not generally accepted by the medical community. Sufficient evidence that is not supported by CMS recognized compendia or acceptable peer reviewed literature is defined as any of the following:
    - Whether the clinical characteristics of the patient and the cancer are adequately represented in the published evidence.
    - Whether the administered chemotherapy/biologic therapy/immune therapy/targeted therapy/other oncologic therapy regimen is adequately represented in the published evidence.
    - Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients. Generally, the definitions of Clinically Meaningful outcomes are those recommended by ASCO, e.g., Hazard Ratio of less than 0.80 and the recommended survival benefit for OS and PFS should be at least 3 months.
    - Whether the experimental design, considering the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover).
    - That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.
    - That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
    - That abstracts (including meeting abstracts) without the full article from the approved peer-reviewed journals lack supporting clinical evidence for determining accepted uses of drugs.

CODING AND STANDARDS

Codes

- J8999 - zanubrutinib

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

POLICY HISTORY

Date	Summary
March 2026	• Updated maximum dosage form quantities in exclusion criteria • Updated references
March 2025	• Converted to new Evolent guideline template • This guideline replaces UM ONC_1377 Brukinsa (zanubrutinib) • Added new indication • Updated references
April 2024	• Added follicular lymphoma indication to include use with obinutuzumab • Added new reference • Updated NCH verbiage to Evolent

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

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