Evolent Clinical Guideline 3038 for Gazyva™ (obinutuzumab)

Guideline Number:	Applicable Codes	
Evolent_CG_3038		
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STATEMENT

Purpose

To define and describe the accepted indications for Gazyva (obinutuzumab) 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.

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

- Gazyva (obinutuzumab) may be used in members with CD20 positive CLL/SLL as a single agent or in combination with chemotherapy as any of the following:
  - Initial therapy as a single agent OR in combination with chemotherapy/venetoclax OR
  - Treatment of relapsed or refractory disease in combination with chemotherapy/venetoclax OR
  - Maintenance therapy, as a single agent, for up to two years.
- NOTE: The following regimens are not supported by Evolent Policy based on the lack of Level 1 Evidence (randomized clinical trials and/or meta-analyses) to show superior outcomes compared to Evolent recommended alternatives agents/regimens, including but not limited to regimens at **Evolent Pathways**.
  - Initial or subsequent therapy with or without del (17p)/ TP53 mutation: Acalabrutinib + Obinutuzumab; Ibrutinib + Obinutuzumab.
  - The above policy position is based on findings from randomized trials that do not show any additional overall survival benefit of adding an anti-CD-20 antibody such as obinutuzumab to acalabrutinib or to ibrutinib, compared to single agent acalabrutinib or single agent ibrutinib.

Follicular Lymphoma (FL)

- Gazyva (obinutuzumab) may be used in members with CD20 positive Follicular Lymphoma as a single agent or in combination with chemotherapy as any of the following:
  - Initial therapy, in combination with chemotherapy OR
  - Treatment of relapsed or refractory disease in combination with chemotherapy OR
  - Maintenance therapy, as a single agent, for up to two years.

CONTRAINDICATIONS/WARNINGS

- Contraindications
  - Gazyva (obinutuzumab) is contraindicated in members with known hypersensitivity reactions (e.g., anaphylaxis) to Gazyva (obinutuzumab) or any of the excipients, including serum sickness with prior Gazyva (obinutuzumab) use.
- US Boxed Warning
  - Hepatitis B virus (HBV) reactivation, in some cases resulting in fulminant hepatitis, hepatic failure, and death, can occur in patients receiving CD20-directed cytolytic antibodies, including obinutuzumab. Screen all patients for HBV infection before treatment initiation. Monitor HBV-positive patients during and after treatment with obinutuzumab. Discontinue obinutuzumab and concomitant medications in the event of HBV reactivation.
  - Progressive multifocal leukoencephalopathy (PML), including fatal PML, can occur in patients receiving obinutuzumab.

EXCLUSION CRITERIA

- Disease progression while taking Gazyva (obinutuzumab).
- Dosing exceeds single dose limit of Gazyva (obinutuzumab) 1,000 mg.
- Treatment with Gazyva (obinutuzumab) exceeds the total duration limit of 8 cycles (for initial therapy) and 2 years (for maintenance therapy).
- Investigational use of Gazyva (obinutuzumab) 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

- J9301 - Injection, obinutuzumab, 10 mg

Applicable Lines of Business

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

POLICY HISTORY

Date	Summary
March 2026	• Updated cycle duration limit in exclusion criteria • Updated contraindications/warnings section • Updated references
March 2025	• Converted to new Evolent guideline template • This guideline replaces UM ONC_1259 Gazyva (obinutuzumab)
March 2024	• Added venetoclax to initial and relapsed/refractory setting under CLL indication • Added venetoclax 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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