# Obinutuzumab (Gazyva®)

## IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

## POLICY

## INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Chronic Lymphocytic Leukemia (CLL)
Gazyva, in combination with chlorambucil, is indicated for the treatment of patients with previously untreated CLL.

Follicular Lymphoma

- Gazyva, in combination with bendamustine followed by Gazyva monotherapy, is indicated for the treatment of patients with follicular lymphoma who relapsed after, or are refractory to, a rituximab-containing regimen.
- Gazyva, in combination with chemotherapy followed by Gazyva monotherapy in patients achieving at least a partial remission, is indicated for the treatment of adult patients with previously untreated stage II bulky, III or IV follicular lymphoma.

Lupus Nephritis (LN)
Gazyva is indicated for the treatment of adult patients with active lupus nephritis who are receiving standard therapy.

Compendial Uses

- Chronic lymphocytic leukemia/ small lymphocytic lymphoma (CLL/ SLL)
- Follicular lymphoma
- Marginal zone lymphomas
  - Extranodal (gastric and non-gastric MALT lymphoma) marginal zone lymphoma
  - Nodal marginal zone lymphoma
  - Splenic marginal zone lymphoma
- Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma
- Mantle cell lymphoma (MCL)
- Diffuse large B-cell lymphoma
- High-grade B-cell lymphomas (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified)
- Burkitt lymphoma
- HIV-related B-cell lymphomas
- Post-transplant lymphoproliferative disorders

- Castleman's disease
- Hairy Cell Leukemia

All other indications are considered experimental/investigational and not medically necessary.

**DOCUMENTATION**

Submission of the following information is necessary to initiate the prior authorization review:

- For TP53-mutated CLL/SLL and MCL: documentation of the presence of TP53-mutation.
- For lupus nephritis:
  - Initial requests: medical records (e.g., chart notes, lab reports) documenting kidney biopsy supporting the diagnosis.
  - Continuation requests: medical records (e.g., chart notes, lab reports) documenting disease stability or improvement.

**COVERAGE CRITERIA**

**Chronic Lymphocytic Leukemia (CLL) and Small Lymphocytic Lymphoma (SLL)**

- Authorization of 6 months may be granted for the treatment of CLL/SLL as a single agent or in combination with acalabrutinib, venetoclax, acalabrutinib and venetoclax, bendamustine, or chlorambucil.
- Authorization of 6 months may be granted in combination with high-dose methylprednisolone for the treatment of CLL/SLL with del(17p)/TP53 mutation when used as first-line treatment or for relapsed/refractory disease.

**Follicular Lymphoma (FL)**

Authorization of 6 months, up to 30 months total, may be granted for the treatment of follicular lymphoma when any of the following criteria are met:

- The requested medication will be used in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) regimen, CVP (cyclophosphamide, vincristine and prednisone) regimen, or bendamustine as first line therapy.
- The requested medication will be used as a single agent or in combination with lenalidomide, bendamustine, CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) or CVP (cyclophosphamide, vincristine, and prednisone) for subsequent therapy.
- The requested medication will be used as maintenance therapy as a single agent.
- The requested medication will be used as a substitute for rituximab in members experiencing intolerance or rare complications from rituximab such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis.
- The requested medication will be used in combination with zanubrutinib (Brukinsa) as third line and subsequent therapy.

**Lupus Nephritis**

Authorization of 12 months may be granted for treatment of active lupus nephritis when both of the following criteria are met:

- Prior to initiating therapy, lupus nephritis was confirmed on kidney biopsy, unless contraindicated.
- Member is receiving a standard therapy regimen (e.g., cyclophosphamide, mycophenolate mofetil, azathioprine, glucocorticoids).

**Extranodal Marginal Zone Lymphoma and Splenic Marginal Zone Lymphoma**

Authorization of 6 months may be granted for the treatment of extranodal marginal zone lymphoma (gastric and non-gastric MALT lymphoma) or splenic marginal zone lymphoma when any of the following criteria are met:

- The requested medication will be used as subsequent therapy in combination with bendamustine or lenalidomide.
- The requested medication be used as maintenance therapy when the member has been previously treated with the requested medication and bendamustine.
- The requested medication is used as a substitute for rituximab in members experiencing intolerance or rare complications from rituximab such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis.

**Nodal Marginal Zone Lymphoma**

Authorization of 6 months may be granted for the treatment of nodal marginal zone lymphoma when any of the following criteria are met:

- The requested medication will be used as first-line therapy in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone) regimen, CVP (cyclophosphamide, vincristine and prednisone) regimen, or bendamustine.
- The requested medication will be used as subsequent therapy in combination with bendamustine or lenalidomide.
- The requested medication be used as maintenance therapy when the member has been previously treated with the requested medication and bendamustine.
- The requested medication is used as a substitute for rituximab in members experiencing intolerance or rare complications from rituximab such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis.

**Hairy Cell Leukemia**

Authorization of 6 months may be granted in combination with vemurafenib as initial therapy for treatment of hairy cell leukemia in members who are unable to tolerate purine analogs.

**B-Cell Lymphomas when used as pre- treatment with glofitamab (Columvi)**

Authorization of 1 month may be granted for treatment of mantle cell lymphoma, diffuse large B-cell lymphoma, high-grade B-cell lymphomas, histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, HIV-related B-cell lymphomas and post-transplant lymphoproliferative disorders when used as single agent pre-treatment for up to 1 dose in cycle 1 of glofitamab therapy.

**Mantle Cell Lymphoma**

Authorization of 6 months may be granted for mantle cell lymphoma when either of the following criteria are met:

- The requested medication will be used as induction therapy for TP53 mutated disease and in combination with Venclexta (venetoclax) and Brukinsa (zanubrutinib).
- The requested medication is used as a substitute for rituximab in members experiencing intolerance or rare complications from rituximab such as mucocutaneous reactions including paraneoplastic pemphigus,

Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis.

**Histologic Transformation of Indolent Lymphomas to Diffuse Large B-Cell Lymphoma, Diffuse Large B-Cell Lymphoma, High-Grade B-Cell Lymphomas (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified), Burkitt Lymphoma, HIV-Related B-Cell Lymphomas, Post-Transplant Lymphoproliferative Disorders, and Castleman's Disease**

Authorization of 6 months may be granted for the treatment of histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma, diffuse large B-cell lymphoma, high-grade B-cell lymphomas (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified), Burkitt lymphoma, HIV-related B-cell lymphomas, post-transplant lymphoproliferative disorders, or Castleman's disease when the requested medication is used as a substitute for rituximab in members experiencing intolerance or rare complications from rituximab such as mucocutaneous reactions including paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis.

**CONTINUATION OF THERAPY**

**Follicular Lymphoma (FL)**

Authorization of 12 months, up to 30 months total, may be granted for continued treatment in members requesting reauthorization for follicular lymphoma when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

**Lupus Nephritis**

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for lupus nephritis who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition.

**B-Cell Lymphomas when used as pre- treatment with glofitamab (Columvi)**

All members (including new members) requesting authorization for continuation of therapy must meet all requirements in the coverage criteria.

**All other indications**

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

**APPENDIX**

Re-challenge with the same anti-CD20 monoclonal antibody is not recommended and it is unclear if the use of an alternative anti-CD20 monoclonal antibody poses the same risk of recurrence.

**APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS**

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

## ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

## REFERENCES

1. Gazyva [package insert]. South San Francisco, CA: Genentech, Inc.; October 2025.
2. The NCCN Drugs & Biologics Compendium® © 2025 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed June 2, 2025.
3. Bajema IM, Wilhelmus S, Alpers CE, et al. Revision of the International Society of Nephrology/Renal Pathology Society classification for lupus nephritis: clarification of definitions, and modified National Institutes of Health activity and chronicity indices. Kidney Int. 2018;93(4):789-796. https://www.sciencedirect.com/science/article/pii/S0085253817308591. Accessed November 12, 2025.

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| **EFFECTIVE DATE** | 11/8/2013 | (11/8/13 - Approved and implemented via executive decision) |
| | 9/16/2015 | (7/13/15 - Approved by MPRC) |
| | 8/17/2016 | (8/17/16 - Annual P&T Committee Review) |
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| | 12/1/2016 | (12/1/16 - Approved and Implemented by Executive Decision) |
| | 4/10/2018 | (4/10/18 - Approved by P&T Corporate Subcommittee) |
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| | 10/31/2019 | (8/13/19 - Approved by P&T Corporate Subcommittee) |
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BlueCross BlueShield of Tennessee

# Policy

## Medical Policy Manual **Approved Rev: Do Not Implement until 4/30/26**

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| 1/1/2024 | (10/10/23 - CHS - Approved by P&T Corporate Subcommittee) |
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