Drug Coverage Policy

Effective Date.....2/1/2026
Coverage Policy Number.....IP0770
Policy Title...Gazyva for Non-Oncology Uses

Injectable – CD20-Directed Antibody – Gazyva for Non-Oncology Uses

- **Gazyva® (obinutuzumab intravenous infusion – Genentech)**

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW

Gazyva, a CD20-directed antibody, is indicated for the treatment of: [1]

- **Chronic lymphocytic leukemia**, in combination with chlorambucil in previously untreated patients.
- **Follicular lymphoma**, in combination with bendamustine followed by Gazyva monotherapy, for patients who relapse or are refractory to a rituximab containing regimen.
- **Follicular lymphoma, stage II bulky, III or IV**, in combination with chemotherapy, followed by Gazyva monotherapy for patients achieving at least a partial remission, in previously untreated patients.
- Active **lupus nephritis**, in adults who are receiving standard therapy.

Dosing

The approved dosing regimen for Gazyva recommends up to 6 cycles (6 months) of therapy for chronic lymphocytic leukemia.[1] For follicular lymphoma, the FDA approved dosing regimen for Gazyva recommends up to 6 months (six 28-day cycles or up to eight 21-day cycles) of therapy. Patients with relapsed or refractory follicular lymphoma who achieve stable disease, or a complete or partial response; or patients with previously untreated follicular lymphoma who achieve a complete or partial response, should continue Gazyva monotherapy for up to 2 years.

In the GADOLIN study, adults with rituximab refractory non-Hodgkin lymphoma were randomized to treatment with Gazyva 1,000 mg on Days 1, 8, and 15 of Cycle 1 and on Day 1 of Cycles 2 through 6 plus bendamustine 90 mg/m^2 on Days 1 and 2 of Cycles 1 through 6 or bendamustine 120 mg/m^2 on Days 1 and 2 of Cycles 1 through 6 (28-day cycles).[2] Patients without disease progression in the Gazyva plus bendamustine group could receive maintenance therapy with Gazyva 1,000 mg once every 2 months for up to 2 years. Patients in the Gazyva and bendamustine group had significantly longer progression-free survival than the bendamustine monotherapy group.

Guidelines

Gazyva is addressed in National Comprehensive Cancer Network guidelines:

- **B-cell lymphomas:** Guidelines (version 3.2024 – August 26, 2024) recommend Gazyva for the first-line and second-line treatment of follicular lymphoma or nodal marginal zone lymphoma in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, and prednisone), CVP (cyclophosphamide, vincristine, and prednisone), bendamustine, or lenalidomide; as third-line and subsequent treatment in combination with Brukinsa® (zanubrutinib capsule); or as single agent maintenance treatment.[3,5] The guidelines also recommend Gazyva as first-line treatment of nodal marginal zone lymphoma; second-line or maintenance therapy for nodal marginal zone lymphoma, extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, and splenic marginal zone lymphoma. Gazyva, in combination with Venclexta® (venetoclax tablets) and Brukinsa, is recommended for the first-line treatment of mantle cell lymphoma with TP53 mutation; and can also be substituted for rituximab in mantle cell lymphoma. Gazyva is also recommended as a substitute for rituximab products (Rituxan, biosimilars) in patients with intolerance or experiencing rare complications, regardless of histology. Finally, Gazyva is recommended as pretreatment, 7 days prior to the administration of Columvi™ (glofitamab-gxbm intravenous infusion) for the treatment of diffuse large B-cell lymphoma (DLBCL), histologic transformation of indolent lymphomas to DLBCL, high-grade B-cell lymphoma, HIV-related B-cell lymphoma, and post-transplant lymphoproliferative disorders.
- **Castleman Disease:** Guidelines (version 1.2024 – January 18, 2024) recommend Gazyva as a substitute for rituximab products (Rituxan, biosimilars) in patients with intolerance or experiencing rare complications.[3,8]
- **Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL):** Guidelines (version 1.2025 – October 1, 2024) recommend Gazyva for the first-line treatment of

CLL/SLL without del(17p)/TP53 mutation in patients with indications for treatment, Gazyva is recommended in combination with bendamustine, chlorambucil, Calquence® (acalabrutinib capsules), Venclexta, Imbruvica® (ibrutinib capsules and tablets), high-dose methylprednisolone; or as a single-agent.[3,4] Gazyva is also recommended as a single agent or in combination with Venclexta, Calquence, or high-dose methylprednisolone for the first-line treatment of CLL/SLL with del(17p)/TP53 mutation; as second-line or subsequent treatment in combination with Venclexta for CLL/SLL with or without del(17p)/TP53 mutation; as a single agent or in combination with high-dose methylprednisolone for relapsed or refractory CLL/SLL without del(17p)/TP53 mutation; in combination with high-dose methylprednisolone for relapsed or refractory CLL/SLL with del(17p)/TP53 mutation; and in combination with Venclexta for retreatment for late relapse after a period of remission in patients with or without del(17p)/TP53 mutations.

- **Hairy Cell Leukemia:** Guidelines (version 1.2025 – September 26, 2024) recommend Gazyva in combination with Zelboraf® (vemurafenib tablets) for initial treatment in patients who cannot tolerate purine analogs including frail patients and those with active infections.[3,6]

Lupus Nephritis

Guidelines for the management of lupus nephritis from Kidney Disease: Improving Global Outcomes (KDIGO) [2024] include consideration of anti-CD20 therapy (e.g., rituximab, obinutuzumab) for patients with Class III or IV biopsy-confirmed lupus nephritis who have an inadequate response or intolerance to standard induction regimens.[9] Anti-CD20 agents are not recommended as initial therapy; rather, they are reserved for refractory or relapsing disease.

The 2024 American College of Rheumatology lupus nephritis guidelines recommend anti-CD20 therapy, such as rituximab or obinutuzumab, only for patients with refractory or relapsing disease who do not respond to standard induction regimens (e.g., mycophenolate, cyclophosphamide, belimumab, or calcineurin inhibitors).[10]

Coverage Policy

POLICY STATEMENT

Prior Authorization is required for benefit coverage of Gazyva. Approval is required for those who meet the **Criteria** and **Dosing** for the listed indications. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Gazyva as well as the monitoring required for adverse events and long-term efficacy, approval requires Gazyva to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Certain indications and/or approval conditions that are delegated to EviCore by Evernorth will follow Oncology Medications (1403) coverage policy for prior authorization medical necessity criteria. Note: Any listed preferred product requirements in this coverage policy, inclusive of oncology and/or oncology-related uses, are applicable as noted.

Gazyva is considered medically necessary when the following is met:

FDA-Approved Indications

1. **Lupus Nephritis**. Approve for the duration noted if the patient meets ONE of the following (A or B):
   - **A)** Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, iii, and iv):
     - **i.** Patient is ≥ 18 years of age; AND
     - **ii.** Diagnosis of lupus nephritis has been confirmed on biopsy; AND
       Note: For example, World Health Organization class III, IV, or V lupus nephritis.
     - **iii.** The medication is being used concurrently with an immunosuppressive regimen; AND
       Note: Examples of an immunosuppressive regimen include azathioprine, cyclophosphamide, leflunomide, methotrexate, mycophenolate mofetil and/or a systemic corticosteroid.
     - **iv.** The medication is prescribed by or in consultation with a nephrologist or rheumatologist; OR
   - **B)** Patient is Currently Receiving Gavyza. Approve for 1 year if the patient meets ALL of the following (i, ii, and iii):
     - **i.** The medication is being used concurrently with an immunosuppressive regimen; AND
       Note: Examples of an immunosuppressive regimen include azathioprine, cyclophosphamide, leflunomide, methotrexate, mycophenolate mofetil and/or a systemic corticosteroid.
     - **ii.** According to the prescriber, patient has responded to the medication.
       Note: Examples of a response include improvement in organ dysfunction, reduction in flares, reduction in corticosteroid dose, reduction in proteinuria, decrease in anti-dsDNA titers, and improvement in complement levels (i.e., C3, C4).
     - **iii.** The medication is prescribed by or in consultation with a nephrologist or rheumatologist.

   Dosing. Approve 1,000 mg administered intravenously once, then 1,000 mg intravenously at Week 2, 24, and 26, followed by 1,000 mg intravenously every 6 months.

Conditions Not Covered

Gazyva for any other non-oncology use is considered not medically necessary. Criteria will be updated as new published data are available.

References

1. Gazyva® intravenous infusion [prescribing information]. South San Francisco, CA: Genentech; October 2025.
2. Sehn LH, Chua N, Mayer J, et al. Obinutuzumab plus bendamustine versus bendamustine monotherapy in patients with rituximab-refractory indolent non-Hodgkin lymphoma (GADOLIN): a randomized, controlled, open-label, multicenter, phase 3 trial. *Lancet Oncol*. 2016;17:1081-1093.
3. The NCCN Drugs and Biologics Compendium. © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on November 26, 2024. Search term: obinutuzumab.
4. The NCCN Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma Clinical Practice Guidelines in Oncology (version 1.2025 – October 1, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on November 26, 2024.
5. The NCCN B-Cell Lymphomas Clinical Practice Guidelines in Oncology (version 3.2024 – August 26, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on November 26, 2024.

6. The NCCN Hairy Cell Leukemia Clinical Practice Guidelines in Oncology (version 1.2025 – September 26, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on November 26, 2024.
7. Columvi™ intravenous infusion [prescribing information]. South San Francisco, CA: Genentech; June 2023.
8. The NCCN Castleman Disease Clinical Practice Guidelines in Oncology (version 1.2024 – January 18, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on November 26, 2024.
9. Kidney Disease: Improving Global Outcomes (KDIGO) Lupus Nephritis Work Group. KDIGO 2024 Clinical Practice Guideline for the management of Lupus Nephritis. *Kidney Int*. 2024;105(1S):S1-S69.
10. Sammaritano L, Askanase A, Bermas B, et al. 2024 American College of Rheumatology (ACR) Guidelines for the Screening, Treatment, and Management of Lupus Nephritis. Published: May 7, 2025. Available at: https://rheumatology.org/lupus-guideline. Accessed: October 21, 2025

Coding Information

Note: 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J9301	Injection, obinutuzumab, 10 mg

Revision Details

Type of Revision	Summary of Changes	Date
New	New policy.	2/1/2026

The policy effective date is in force until updated or retired.