Drug Policy:

Rituximab Products

POLICY NUMBER UM ONC_1132	SUBJECT Rituximab Products: Rituxan (rituximab), Truxima (rituximab-abbs), Ruxience (rituximab-pvvr) , Riabni (rituximab-arrx), Rituxan Hycela (rituximab and hyaluronidase)		DEPT/PROGRAM UM Dept	PAGE 1 of 4
DATES COMMITTEE REVIEWED 07/22/11, 01/02/13, 03/13/13, 07/24/14, 12/16/15, 12/21/16, 12/03/17, 11/08/18, 01/09/19, 08/14/19, 12/11/19, 02/12/20, 03/11/20, 04/08/20, 10/14/20, 02/10/21, 11/15/21, 01/12/22, 03/09/22, 05/11/22, 06/08/22, 09/14/22, 10/12/22, 02/08/23, 03/08/23, 04/12/23, 06/14/23, 06/12/24	APPROVAL DATE June 12, 2024	EFFECTIVE DATE June 28, 2024	COMMITTEE APPROVAL DATES 07/22/11, 01/02/13, 03/13/13, 07/24/14, 12/16/15, 12/21/16, 12/03/17, 11/08/18, 01/09/19, 08/14/19, 12/11/19, 02/12/20, 03/11/20, 04/08/20, 10/14/20, 02/10/21, 11/15/21, 01/12/22, 03/09/22, 05/11/22, 06/08/22, 09/14/22, 10/12/22, 02/08/23, 03/08/23, 04/12/23, 06/14/23, 06/12/24	
PRIMARY BUSINESS OWNER: UM		COMMITTEE/BOARD APPROVAL Utilization Management Committee		
NCQA STANDARDS UM 2		ADDITIONAL AREAS OF IMPACT		
CMS REQUIREMENTS	STATE/FEDERAL REQUIREMENTS		APPLICABLE LINES OF BUSINESS Commercial, Exchange, Medicaid	

I. PURPOSE

To define and describe the accepted indications for Rituximab Products [Rituxan (rituximab), Truxima (rituximab-abbs), Ruxience (rituximab-pvvr), Riabni (rituximab-arrx), Rituxan Hycela (rituximab and hyaluronidase)] 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 recommended 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.

II. INDICATIONS FOR USE/INCLUSION CRITERIA

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

1. The requested medication was used within the last year, AND
2. The member has not experienced disease progression and/or no intolerance to the requested medication, AND

3. Additional medication(s) are not being added to the continuation request.

B. CD-20 positive B-Cell Non-Hodgkin's Lymphomas (NHL) and Acute Lymphoblastic Leukemia (B-ALL)

1. The member is an adult or pediatric member greater than or equal to 6 months of age who has CD20 positive B-cell NHL (e.g., follicular, diffuse large B-cell, Mantle Cell Lymphoma, pediatric aggressive mature B-Cell Lymphomas) or B-ALL and rituximab/rituximab biosimilar may be used as a single agent or in combination with chemotherapy for ANY of the following:
   a. Initial therapy (for use in combination with chemotherapy only) OR
   b. Treatment of relapsed or refractory disease OR
   c. Maintenance therapy:
      i. For up to two years for Indolent B-Cell Lymphomas (Follicular B Cell Lymphoma and all subtypes of Marginal Zone Lymphoma).
      ii. For up to disease progression or intolerable toxicity for Mantle Cell Lymphoma.
   d. In members with DLBLC or High-Grade B-Cell Lymphoma (HGBL): Use of R-polatuzunab-CHP (rituximab + polatuzunmab + cyclophosphamide + doxorubicin + prednisone) as first line/initial treatment for an International Prognostic Index (IPI) score of 2 or greater.
2. NOTE: The following regimens are not supported by Evolent Policy due to a lack of Level 1 Evidence (randomized clinical trials and/or meta-analyses) to show superior outcomes/lower toxicity compared to alternative agents/regimens, including but not limited to regimens at (http://pathways.newcenturyhealth.com).
   a. In relapsed/refractory DLBCL: Gemcitabine + vinorelbine +/- rituximab (any rituximab product)
   b. Maintenance for DLBCL: single agent rituximab (any rituximab product)
   c. As initial therapy for Marginal Zone Lymphoma: lenalidomide + rituximab (any rituximab product)
   d. As second line or subsequent therapy for Mantle Cell Lymphoma: Ibrutinib + lenalidomide + rituximab (any rituximab product); venetoclax + rituximab (any rituximab product).

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

1. Rituximab/rituximab biosimilar may be used for first or subsequent line of therapy:
   a. In combination with chemotherapy OR
   b. As maintenance therapy for up to 2 years
2. NOTE: The following regimens are not supported by Evolent Policy due to the lack of Level 1 Evidence (randomized clinical trial and/or meta-analyses) to show superior outcomes compared to alternative agents/regimens, including but not limited to regimens at (http://pathways.newcenturyhealth.com).
   a. Initial therapy: ibrutinib + rituximab (any rituximab product)
   b. Subsequent therapy: lenalidomide +/- rituximab (any rituximab product).

D. Hodgkin's Lymphoma -Nodular Lymphocyte Predominant CD-20 + Hodgkin's Lymphoma

1. The member has nodular lymphocyte predominant Hodgkin's Lymphoma and rituximab/rituximab biosimilar may be used as a single agent or in combination with chemotherapy for initial or subsequent therapy OR
2. Rituximab/rituximab biosimilar may be used for maintenance therapy for up to 2 years.

E. Idiopathic Thrombocytopenic Purpura (ITP)

1. The member has acute ITP and rituximab/rituximab biosimilar may be used as a single agent AND the following:
    a. The member has ITP that is refractory to corticosteroids AND
    b. The platelet count is less than 30 x 10^9/L OR
    c. There are other clinical indications for therapy.

F. Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma

1. The member has Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma and rituximab/rituximab biosimilar may be used in combination with chemotherapy and/or a BTK inhibitor (e.g., ibrutinib + rituximab) as primary therapy or as therapy for relapsed/refractory disease.

III. EXCLUSION CRITERIA

A. Use of any Rituximab products (Rituxan, Rituxan Hycela, Truxima, Ruxience, Riabni) as maintenance therapy after primary treatment of Diffuse Large B-Cell Lymphoma (DLBCL).

B. Treatment exceeds the maximum months duration limit of 2 years when used in combination with Venclexta (venetoclax) for the treatment of CLL.

C. Dosing exceeds single dose limit of rituximab products 500 mg/m^2 (CLL) and 375 mg/m^2 (NHL); Rituxan Hycela 1600 mg (CLL) and 1400 mg (NHL).

D. Investigational use of Rituximab Products (Rituxan, Rituxan Hycela, Truxima, Ruxience, Riabni) 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 recommended by CMS recognized compendia or acceptable peer reviewed literature is defined as any of the following:
    1. Whether the clinical characteristics of the patient and the cancer are adequately represented in the published evidence.
    2. Whether the administered chemotherapy/biologic therapy/immune therapy/targeted therapy/other oncologic therapy regimen is adequately represented in the published evidence.
    3. 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.
    4. 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).
    5. 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.
    6. That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
    7. 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.

IV. MEDICATION MANAGEMENT

A. Please refer to the FDA label/package insert for details regarding these topics.

V. APPROVAL AUTHORITY

A. Review – Utilization Management Department

B. Final Approval – Utilization Management Committee

VI. ATTACHMENTS

A. None

VII. REFERENCES

A. Tilly H, et al. POLARIX Clinical Trial. Polatuzumab Vedotin in Previously Untreated Diffuse Large B-Cell Lymphoma. N Engl J Med. 2022 Jan 27;386(4):351-363.

B. Rozental A, et al. The role of maintenance therapy in patients with diffuse large B cell lymphoma: A systematic review and meta-analysis. Hematol Oncol. 2019 Feb;37(1):27-34.

C. Leonard JP, et al. AUGMENT Clinical Trial. A Phase III Study of Lenalidomide Plus Rituximab Versus Placebo Plus Rituximab in Relapsed or Refractory Indolent Lymphoma. J Clin Oncol. 2019 May 10;37(14):1188-1199.

D. Riabni prescribing information. Amgen. Thousand Oaks, CA 2022.

E. Rituxan Hycela prescribing information. Genentech, Inc. San Francisco, CA 2022.

F. Truxima (rituximab-abbs) prescribing information. Teva Pharmaceuticals USA, Inc. North Wales, PA 2022.

G. Rituxan prescribing information. Genentech, Inc. San Francisco, CA 2022.

H. Ruxience (rtuximab-pvvr) prescribing information. Pfizer Inc. NY, NY 2021.

I. Clinical Pharmacology Elsevier Gold Standard 2023.

J. Micromedex® Healthcare Series: Micromedex Drugdex Ann Arbor, Michigan 2023.

K. National Comprehensive Cancer Network. Cancer Guidelines and Drugs and Biologics Compendium 2023.

L. AHFS Drug Information. American Society of Health-Systems Pharmacists or Wolters Kluwer Lexi-Drugs. Bethesda, MD 2023.

M. Ellis LM, et al. American Society of Clinical Oncology perspective: Raising the bar for clinical trials by defining clinically meaningful outcomes. J Clin Oncol. 2014 Apr 20;32(12):1277-80.

N. Medicare Benefit Policy Manual Chapter 15 Covered Medical and Other Health Services: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.