

STANDARD MEDICARE PART B MANAGEMENT

RITUXAN HYCELA (rituximab and hyaluronidase human)

POLICY

I. 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.

A. FDA-Approved Indications

1. Adult patients with follicular lymphoma (FL):
 - a. Relapsed or refractory, follicular lymphoma as a single agent
 - b. Previously untreated follicular lymphoma in combination with first line chemotherapy and, in patients achieving a complete or partial response to rituximab in combination with chemotherapy, as single-agent maintenance therapy
 - c. Non-progressing (including stable disease), follicular lymphoma as a single agent after first-line CVP (cyclophosphamide, vincristine, and prednisone) chemotherapy
2. Adult patients with previously untreated diffuse large B-cell lymphoma (DLBCL) in combination with cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP) or other anthracycline-based chemotherapy regimens
3. Adult patients with previously untreated and previously treated chronic lymphocytic leukemia (CLL), in combination with fludarabine and cyclophosphamide (FC)

Limitations of Use:

Initiate treatment with Rituxan Hycela only after patients have received at least one full dose of a rituximab product by intravenous infusion.

Rituxan Hycela is not indicated for the treatment of non-malignant conditions

B. Compendial Uses

1. B-cell lymphomas:
 - a. Castleman's disease (CD)
 - b. High grade B-cell lymphoma (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)
 - c. Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma
 - d. Marginal zone lymphomas
 - i. Nodal marginal zone lymphoma
 - ii. Gastric mucosa associated lymphoid tissue (MALT) lymphoma
 - iii. Nongastric MALT lymphoma
 - iv. Splenic marginal zone lymphoma
 - e. Mantle cell lymphoma
2. Post-transplant lymphoproliferative disorder (PTLD)

3. Hairy cell leukemia
4. Primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas)
5. Small lymphocytic lymphoma (SLL)
6. Waldenström Macroglobulinemia/ Lymphoplasmacytic Lymphoma

All other indications will be assessed on an individual basis. Submissions for indications other than those enumerated in this policy should be accompanied by supporting evidence from Medicare approved compendia.

II. CRITERIA FOR INITIAL APPROVAL

Prior to initiating therapy, all members must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions.

A. Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL)

Authorization of 12 months may be granted for treatment of CD20 positive CLL or SLL.

B. Hairy cell leukemia (HCL)

Authorization of 12 months may be granted for treatment of CD20 positive HCL.

C. B-cell lymphomas

Authorization of 12 months may be granted for treatment of any of the following oncologic disorders that are CD20-positive as confirmed by testing or analysis:

1. Castleman's disease (CD)
2. Diffuse large B-cell lymphoma (DLBCL)
3. Follicular lymphoma
4. High grade B-cell lymphoma (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)
5. Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma
6. Mantle cell lymphoma
7. Nodal marginal zone lymphoma
8. Post-transplant lymphoproliferative disorder (PTLD)
9. Marginal zone lymphomas
 - i. Nodal marginal zone lymphoma
 - ii. Gastric mucosa associated lymphoid tissue (MALT) lymphoma
 - iii. Nongastric MALT lymphoma
 - iv. Splenic marginal zone lymphoma

D. Primary cutaneous B-cell lymphoma

Authorization of 12 months may be granted for treatment of CD20 positive primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas).

E. Waldenström Macroglobulinemia/ Lymphoplasmacytic Lymphoma

Authorization of 12 months may be granted for treatment of CD20 positive Waldenström macroglobulinemia/ lymphoplasmacytic lymphoma.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must be currently receiving therapy with the requested agent.

Authorization for 12 months may be granted when all of the following criteria are met:

1. The member is currently receiving therapy with Rituxan Hycela.
2. Rituxan Hycela is being used to treat an indication enumerated in Section II.
3. The member is receiving benefit from therapy. Benefit is defined as no unacceptable toxicity while on the current regimen.

IV. SUMMARY OF EVIDENCE

The contents of this policy were created after examining the following resources:

1. The prescribing information for Rituxan Hycela.
2. The available compendium
 - a. National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
 - b. Micromedex DrugDex
 - c. American Hospital Formulary Service- Drug Information (AHFS-DI)
 - d. Lexi-Drugs
 - e. Clinical Pharmacology
3. NCCN Guideline: Hairy cell leukemia
4. NCCN Guideline: Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma
5. NCCN Guideline: Hodgkin lymphoma
6. NCCN Guideline: Primary cutaneous lymphomas
7. NCCN Guideline: Chronic lymphocytic leukemia/small lymphocytic lymphoma
8. NCCN Guideline: B-cell lymphomas

After reviewing the information in the above resources, the FDA-approved indications listed in the prescribing information for Rituxan Hycela are covered in addition to the following:

1. B-cell lymphomas:
 - a. Castleman's disease (CD)
 - b. High grade B-cell lymphoma (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)
 - c. Histologic transformation of indolent lymphomas to diffuse large B-cell lymphoma
 - d. Marginal zone lymphomas
 - i. Nodal marginal zone lymphoma
 - ii. Gastric mucosa associated lymphoid tissue (MALT) lymphoma
 - iii. Nongastric MALT lymphoma
 - iv. Splenic marginal zone lymphoma
 - e. Mantle cell lymphoma
2. Post-transplant lymphoproliferative disorder (PTLD)
3. Hairy cell leukemia
4. Primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas)
5. Small lymphocytic lymphoma (SLL)
6. Waldenström Macroglobulinemia/ Lymphoplasmacytic Lymphoma

Reference number(s)
4475-A

V. EXPLANATION OF RATIONALE

Support for FDA-approved indications can be found in the manufacturer's prescribing information.

Support for using Rituxan Hycela for the compendial uses listed in section IV can be found in the NCCN Drugs and Biologics Compendium. Use of information in the NCCN Drugs and Biologics Compendium for off-label use of drugs and biologicals in an anti-cancer chemotherapeutic regimen is supported by the Medicare Benefit Policy Manual, Chapter 15, section 50.4.5 (Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen).

VI. REFERENCES

1. Rituxan Hycela [package insert]. South San Francisco, CA: Genentech, Inc.; June 2021.
2. The NCCN Drugs & Biologics Compendium® © 2022 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed April 8, 2022.