VENTURA COUNTY
HEALTH CARE PLAN

# UTILIZATION MANAGEMENT MEDICAL POLICY

**POLICY:** Oncology (Injectable) – Arzerra Utilization Management Medical Policy
- Arzerra® (ofatumumab intravenous infusion – Novartis)

**REVIEW DATE:** 10/20/2021

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## OVERVIEW

Arzerra is indicated for the treatment of **chronic lymphocytic leukemia** (CLL) in the following situations:
- Previously untreated patients, in combination with chlorambucil, in patients for whom fludarabine-based therapy is considered inappropriate;
- Recurrent or progressive CLL, in patients who are in complete or partial response after at least two lines of therapy;
- Refractory CLL, in patients with disease refractory to fludarabine and alemtuzumab;
- Relapsed CLL, in combination with fludarabine and cyclophosphamide.[1]

## Dosing

The FDA-approved treatment duration varies by the indication for use of Arzerra:
- For the first-line treatment of chronic lymphocytic leukemia/small lymphocytic lymphoma, treatment may continue for up to 12 months (12 cycles).
- For relapsed or refractory chronic lymphocytic leukemia/small lymphocytic lymphoma, treatment may continue for up to 6 months or 6 cycles.
- For extended treatment in patients in complete or partial response after $\geq$ 2 lines of therapy, treatment may continue for up to 2 years.[1]

## Guidelines

Arzerra is addressed in the National Comprehensive Cancer Network guidelines:
- **B-cell lymphomas:** Guidelines (version 5.2021 – September 22, 2021) recommend Arzerra as a substitute for rituximab products (Rituxan and biosimilars) and Gazyva® (obinutuzumab injection) in patients with B-cell lymphomas experiencing intolerance or rare complications such as paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, and toxic epidermal necrolysis.[2,5]
- **Chronic lymphocytic leukemia/small lymphocytic lymphoma:** Guidelines (version 1.2022 – September 8, 2021) recommend Arzerra in combination with bendamustine for the first-line treatment of CLL/small lymphocytic lymphoma (SLL) without del(17p)/TP53 mutation; for second-line and subsequent treatment, as a single agent, or in combination with fludarabine and cyclophosphamide for CLL/SLL without del(17p)/TP53 mutation; and for second-line and subsequent treatment, as a single agent for relapsed or refractory disease with del(17p)/TP53 mutation in patients with lymph nodes < 5 cm.[2,3]
- **Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma:** Guidelines (version 1.2022 – June 24, 2021) recommend Arzerra as a single agent or in combination therapy in rituximab products (Rituxan and biosimilars) intolerant patients, anywhere that rituximab is given, for previously treated disease that does not respond to primary treatment or for relapsed or progressive disease.[2,4]

## POLICY STATEMENT

Prior Authorization is recommended for medical benefit coverage of Arzerra. Approval is recommended 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 Arzerra as well as the monitoring required for adverse events and long-term efficacy, approval requires Arzerra to be prescribed by or in consultation with a physician who specializes in the condition being treated.

**Automation:** None.

## RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Arzerra is recommended in those who meet one of the following criteria:

### FDA-Approved Indication

1. **Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma.** Approve for 6 months if the patient meets the following criteria (A and B):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** The medication is prescribed by or in consultation with an oncologist.

   **Dosing.** Approve ONE of the following dosing regimens (A or B):
   - **A)** Previously Untreated Patients, Relapsed Disease, or Extended Treatment (i, ii, and iii):
     - **i.** Approve up to 1,000 mg administered intravenously; AND
     - **ii.** Patient receives a maximum of two doses in the first cycle (28-day or 8-week); AND
     - **iii.** Patient receives a maximum of one dose in each subsequent cycle (28-day or 8-week); OR
   - **B)** Refractory Disease (i, ii, and iii):
     - **i.** Approve up to 2,000 mg administered intravenously; AND
     - **ii.** Patient receives a maximum of eight weekly doses; AND
     - **iii.** Patient then receives a maximum of one dose in each subsequent 4-week cycle.

### Other Uses with Supportive Evidence

2. **B-Cell Lymphoma.** Approve for 6 months if the patient meets the following criteria (A, B, and C):
   Note: Examples include follicular lymphoma, MALT lymphoma, marginal zone lymphoma, mantle cell lymphoma, diffuse large B-cell lymphoma, high-grade B-cell lymphoma.
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient experienced an adverse event or intolerance to a rituximab product or Gazyva (obinutuzumab intravenous infusion); AND
     Note: Examples of adverse events or intolerance include paraneoplastic pemphigus, Stevens-Johnson syndrome, lichenoid dermatitis, vesiculobullous dermatitis, toxic epidermal necrolysis. Examples of rituximab products include Rituxan and biosimilars.
   - **C)** The medication is prescribed by or in consultation with an oncologist.

   **Dosing.** Approve one of the following dosing regimens (A, B, or C):

**A)** Approve up to 1,000 mg administered by intravenous infusion twice during Cycle 1 and then once in each subsequent 21-day cycle; OR
**B)** Approve up to 1,000 mg administered by intravenous infusion once weekly for a total of 8 doses; OR
**C)** Approve up to 1,000 mg administered by intravenous infusion once weekly for 4 doses, and then 1,000 mg once every 8 weeks for 4 doses.

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**3. Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma.** Approve for 6 months if the patient meets the following criteria (A, B, C, and D):
**A)** Patient is ≥ 18 years of age; AND
**B)** Patient is intolerant to a rituximab product; AND
Note: Examples of rituximab products include Rituxan and biosimilars.
**C)** Patient has relapsed or progressive disease; AND
**D)** The medication is prescribed by or in consultation with an oncologist.

**Dosing.** Approve up to 2,000 mg administered intravenously for a maximum of five weekly doses.

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## CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Arzerra is not recommended in the following situations:

**1.** Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

## REFERENCES

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3. The NCCN Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma Clinical Practice Guidelines in Oncology (version 1.2022 – September 8, 2021). © 2021 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on October 14, 2021.
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7. van Imhoff GW, McMillian A, Matasar MJ, et al. Ofatumumab versus rituximab salvage chemoimmunotherapy in relapsed or refractory diffuse large B-cell lymphoma: The ORCHARRD Study. *J Clin Oncol*. 2017;35:544-551.
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12. Rosenbaum CA, Jung SH, Pitcher B, et al. Phase 2 multicentre study of single-agent ofatumumab in previously untreated follicular lymphoma: CALGB 50901 (Alliance). *Br J Haematol*. 2019;185:53-64.
13. Kiesewetter B, Neuper O, Mayerhoefer ME, et al. A pilot phase II study of ofatumumab monotherapy for extranodal marginal zone B-cell lymphoma of the mucosa-associated lymphoid tissue (MALT) lymphoma. *Hematol Oncol*. 2018;36:49-55.

## HISTORY

| Type of Revision | Summary of Changes | Review Date |
|---|---|---|
| Annual Revision | No criteria changes. | 10/14/2020 |
| Annual Revision | No criteria changes. | 10/20/2021 |