Gazyva® (Obinutuzumab)

Policy Number: CS2026D0140A
Effective Date: February 1, 2026

➲ Instructions for Use

Table of Contents **Page**

Application 1
Coverage Rationale 1
Applicable Codes 2
Background 2
Clinical Evidence 2
U.S. Food and Drug Administration 3
References 3
Policy History/Revision Information 3
Instructions for Use 3

Commercial Policy
• Gazyva® (Obinutuzumab)

Application

This Medical Benefit Drug Policy does not apply to the states listed below; refer to the state-specific policy/guideline, if noted:

State	Policy/Guideline
Indiana	Gazyva® (obinutuzumab) (for Indiana Only)
Kansas	None
Louisiana	None
North Carolina	None
Ohio	None

Coverage Rationale

This policy refers to Gazyva (obinutuzumab) for intravenous infusion for non-oncology indications. Refer to the Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage for updated information based upon the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium® (NCCN Compendium®) for oncology indications.

Active Lupus Nephritis

Gazyva (obinutuzumab) is proven and medically necessary for the treatment of active lupus nephritis when all of the following criteria are met:

- For **initial therapy**, **all** of the following:
  - Diagnosis of active lupus nephritis; **and**
  - Provider attestation that diagnosis is biopsy proven or biopsy is contraindicated in the patient; **and**
  - Currently receiving at least **one** standard of care treatment for active systemic lupus erythematosus (e.g., antimalarials, corticosteroids, or immunosuppressants); **and**
  - Patient is not receiving Gazyva in combination with Benlysta (belimumab) or Lupkynis (voclosporin); **and**
  - Gazyva is dosed according to US Food and Drug Administration labeled dosing; **and**
  - Prescribed by or in consultation with a rheumatologist or nephrologist; **and**
  - Initial authorization is for no more than 12 months
- For **continuation of therapy**, **all** of the following:
  - Patient has previously received Gazyva injection for intravenous infusion; **and**
  - Documentation of positive clinical response; **and**

Proprietary Information of UnitedHealthcare. Copyright 2026 United HealthCare Services, Inc.

- Currently receiving at least **one** standard of care treatment for active systemic lupus erythematosus (e.g., antimalarials, corticosteroids, or immunosuppressants; that is not a biologic; **and**
- Patient is not receiving Gazyva in combination with Benlysta (belimumab) or Lupkynis (voclosporin); **and**
- Gazyva is dosed according to US Food and Drug Administration labeled dosing; **and**
- Prescribed by or in consultation with a rheumatologist or nephrologist; **and**
- Authorization is for no more than 12 months

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
J9301	Injection, obinutuzumab, 10 mg

Diagnosis Code	Description
M32.14	Glomerular disease in systemic lupus erythematosus

Background

Obinutuzumab is a monoclonal antibody that targets the CD20 antigen expressed on the surface of pre-B and mature B lymphocytes. Upon binding to CD20, obinutuzumab mediates B-cell lysis through (1) engagement of immune effector cells, (2) by directly activating intracellular death signaling pathways (direct cell death), and/or (3) activation of the complement cascade. The immune effector cell mechanisms include antibody-dependent cellular cytotoxicity (ADCC) and antibody-dependent cellular phagocytosis.

Clinical Evidence

The efficacy of obinutuzumab was evaluated in REGENCY (NCT04221477), a Phase III, randomized, double-blind, placebo-controlled, parallel-group, multicenter study in 271 patients with ISN/RPS 2003 Class III or IV, with or without concomitant Class V lupus nephritis (LN), treated with standard therapy consisting of mycophenolate mofetil (MMF) and corticosteroids. Patients had active or active/chronic ISN/RPS 2003 Class III or IV, with or without concomitant Class V proliferative LN determined by kidney biopsy, current or past positive antinuclear antibody (ANA), urine protein-to-creatinine ratio (UPCR) ≥ 1 g/g, and had received at least one dose of pulse intravenous (IV) methylprednisolone (≥ 250 mg) or equivalent treatment for LN during the 6 months prior to screening or during screening.

Patients with estimated glomerular filtration rate (eGFR) 50% of glomeruli on kidney biopsy, presence of rapidly progressive glomerulonephritis, evidence of active infection, receipt of anti-CD20 therapy < 9 months before or during screening, or receipt of cyclophosphamide, tacrolimus, ciclosporin, or voclosporin within 2 months of or during screening were excluded.

Patients were randomized 1:1 to receive obinutuzumab 1,000 mg (n = 135) or placebo (n = 136) intravenously, in combination with MMF 2-2.5 g/day and a tapering course of corticosteroids and were evaluated over 76 weeks. Patients randomized to receive obinutuzumab were further randomized in a 1:1 ratio to receive either obinutuzumab 1,000 mg IV on Day 1, Weeks 2, 24, 26, 50, and 52 (Arm 1), or obinutuzumab 1,000 mg IV on Day 1, Weeks 2, 24, 26, and 52 (Arm 2).

All patients received oral prednisone 0.5 mg/kg/day (maximum 60 mg/day) and remained at this dose until Week 2. Beginning on Day 15, prednisone was tapered to achieve a target dose of 5 mg/day by Week 24. Prednisone was maintained at a low dose (5 mg/day) from Week 24 until Week 80.

The median age of patients was 31 years, 85% were female, 58% were Hispanic or Latino, 48% were White, 19% were American Indian or Alaska Native, 15% were Black or African American and 6% were Asian. The distribution by kidney biopsy class was 39% Class III, 61% Class IV and 31% had concomitant Class V. Mean (SD) eGFR at baseline 102.3 (±30.8) mL/min/1.73 m2 . Mean (SD) UPCR at baseline was 3.3 (±2.9) mg/mg with 42% of patients exhibiting UPCR ≥ 3 mg/mg at baseline.

Proprietary Information of UnitedHealthcare. Copyright 2026 United HealthCare Services, Inc.

The primary endpoint measure was proportion of patients who achieved complete renal response (CRR) at Week 76, defined as meeting all of the following criteria: UPCR < 0.5 g/g; eGFR ≥ 85% of baseline, as calculated using the 2009 Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) equation; with no occurrence of the following intercurrent events: rescue therapy, treatment failure, death or early study withdrawal.

Key secondary endpoint measures included: proportion of patients who achieved CRR with successful prednisone taper at Week 76 (defined as achievement of CRR at Week 76 without receiving prednisone > 7.5 mg/day or equivalent from Week 64 through Week 76), proportion of patients who achieved a proteinuric response at Week 76 (defined as achievement of UPCR < 0.8g/g and no occurrence of the following intercurrent events: rescue therapy, treatment failure, death or early study withdrawal) and proportion of patients who experience “renal-related events or deaths” through Week 76 (defined as occurrence of death, treatment failure, ≥ 50% increase in UPCR to a value ≥ 3 g/g and/or ≥ 30% decrease in eGFR to < 60 ml/min/1.73 m2).

The proportion of patients achieving CRR at Week 76 was significantly greater in patients treated with obinutuzumab in combination with standard therapy compared to patients who received placebo plus standard therapy. There were also a higher proportion of patients who achieved CRR with successful prednisone taper at Week 76 and proteinuric response at Week 76 in the obinutuzumab plus standard therapy arm compared to the placebo plus standard therapy arm. CRR was achieved in 46.4% of patients in the obinutuzumab arm vs. 33.1% of patients in the placebo arm (difference 13.4, 95% CI: 2.0, 24.8; p = 0.0232).

In the REGENCY study, patients who received obinutuzumab were less likely to experience the outcome of “renal-related event or death” compared with placebo. Fewer patients in the obinutuzumab arm experienced worsening kidney function or doubling of serum creatinine.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Gazyva is a CD20-directed cytolytic antibody indicated:

- In combination with chlorambucil, for the treatment of patients with previously untreated chronic lymphocytic leukemia (CLL).
- In combination with bendamustine followed by Gazyva monotherapy, for the treatment of patients with follicular lymphoma (FL)who relapsed after, or are refractory to, a rituximab-containing regimen.
- In combination with chemotherapy followed by Gazyva monotherapy in patients achieving at least a partial remission, for the treatment of adult patients with previously untreated stage II bulky, III or IV follicular lymphoma.
- For the treatment of adult patients with active lupus nephritis (LN) who are receiving standard therapy.

References

1. Gazyva [package insert]. South San Francisco, CA: Genentech, Inc.; October 2025.

Policy History/Revision Information

Date	Summary of Changes
02/01/2026	• New Medical Benefit Drug Policy

Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection

Proprietary Information of UnitedHealthcare. Copyright 2026 United HealthCare Services, Inc.

with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Proprietary Information of UnitedHealthcare. Copyright 2026 United HealthCare Services, Inc.