

UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

Program Number	2026 P 1306-8
Program	Prior Authorization/Notification
Medication	Brukinsa <sup>®</sup> (zanubrutinib)
P&T Approval Date	1/2020, 1/2021, 10/2021, 10/2022, 10/2023, 7/2024, 7/2025, 2/2026
Effective Date	5/1/2026

**1. Background:**

Brukinsa (zanubrutinib) is a kinase inhibitor indicated for the treatment of patients with mantle cell lymphoma (MCL) who have received at least one prior therapy, relapsed or refractory marginal zone lymphoma (MZL) who have received at least one anti-CD20-based regimen, and relapsed or refractory follicular lymphoma (FL), in combination with obinutuzumab, after two or more lines of systemic therapy. These indications are approved under accelerated approval based on overall response rate. Continued approval for these indications may be contingent upon verification and description of clinical benefit in a confirmatory trial. Brukinsa is also indicated for the treatment of Waldenström’s macroglobulinemia (WM) and chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL).

NCCN recommends Brukinsa for relapsed/refractory hairy cell leukemia and primary central nervous systems (CNS) lymphomas.

**Coverage Information:**

Members will be required to meet the criteria below for coverage. For members under the age of 19 years, the prescription will automatically process without a coverage review.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

**2. Coverage Criteria<sup>a</sup>:**

<p><b>A. <u>Patients less than 19 years of age</u></b></p> <p>1. <b>Brukinsa</b> will be approved based on the following criterion:</p> <p style="padding-left: 40px;">a. Patient is less than 19 years of age</p> <p style="text-align: center;"><b>Authorization will be issued for 12 months.</b></p> <p><b>B. <u>B-Cell Lymphomas</u></b></p> <p>1. <b><u>Initial Authorization</u></b></p> <p style="padding-left: 40px;">a. <b>Brukinsa</b> will be approved based on <b><u>one</u></b> of the following criteria:</p> <p style="padding-left: 80px;">(1) <b><u>All</u></b> of the following:</p>
---

(a) Diagnosis of follicular lymphoma (FL)

**-AND-**

(b) Disease is relapsed, refractory, or progressive

**-AND-**

(c) Patient has received at least two or more lines of systemic therapy

**-AND-**

(d) Brukinsa will be used in combination with obinutuzumab

**-OR-**

(2) **All** of the following:

(a) Diagnosis of **one** of the following:

- i. Extranodal marginal zone lymphoma (EMZL) of the stomach
- ii. Extranodal marginal zone lymphoma of nongastric sites (noncutaneous)
- iii. Nodal marginal zone lymphoma

**-AND-**

(b) Disease is relapsed, refractory, or progressive

**-AND-**

(c) Patient has received at least one anti-CD20-based regimen (e.g., rituximab, obinutuzumab)

**-OR-**

(3) **All** of the following:

(a) Diagnosis of splenic marginal zone lymphoma

**-AND-**

(b) Disease is relapsed or refractory

**-AND-**

(c) Patient has received at least one anti-CD20-based regimen (e.g., rituximab, obinutuzumab)

**-OR-**

(4) Diagnosis of mantle cell lymphoma (MCL)

**Authorization will be issued for 12 months.**

2. **Reauthorization**

a. **Brukina** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Brukina therapy

**Authorization will be issued for 12 months.**

**C. Waldenström's Macroglobulinemia (WM)**

1. **Initial Authorization**

a. **Brukina** will be approved based on the following criterion:

(1) Diagnosis of Waldenström's macroglobulinemia (WM)

**Authorization will be issued for 12 months.**

2. **Reauthorization**

a. **Brukina** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Brukina therapy

**Authorization will be issued for 12 months.**

**D. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL)**

1. **Initial Authorization**

a. **Brukina** will be approved based on the following criterion:

(1) Diagnosis of Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL)

**Authorization will be issued for 12 months.**

2. **Reauthorization**

a. **Brukina** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Brukina therapy

**Authorization will be issued for 12 months.**

#### **E. Hairy Cell Leukemia**

##### **1. Initial Authorization**

- a. **Brukina** will be approved based on the following criteria:

(1) Diagnosis of hairy cell leukemia

**-AND-**

(2) Disease is relapsed, refractory, or progressive

**Authorization will be issued for 12 months.**

##### **2. Reauthorization**

- a. **Brukina** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Brukina therapy

**Authorization will be issued for 12 months.**

#### **F. Central Nervous System Lymphoma**

##### **1. Initial Authorization**

- a. **Brukina** will be approved based on the following criteria:

(1) Diagnosis of primary central nervous system lymphoma

**-AND-**

(2) Disease is relapsed or refractory

**Authorization will be issued for 12 months.**

##### **2. Reauthorization**

- a. **Brukina** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Brukina therapy

**Authorization will be issued for 12 months.**

#### **G. NCCN Recommended Regimens**

The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B

**Authorization will be issued for 12 months.**

<sup>a</sup> State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

### 3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

### 4. References:

1. Brukinsa® [package insert]. Pennington, NJ: BeOne Medicines USA, Inc; June 2025.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium®). Available at [NCCN Drugs and Biologics Compendium®](#). Accessed December 16, 2025.

Program	Prior Authorization/Notification – Brukinsa® (zanubrutinib)
<b>Change Control</b>	
1/2020	New program.
1/2021	Annual review. Background updated to reflect package insert. No changes to coverage criteria. References updated.
10/2021	Clinical coverage criteria added for Waldenström’s Macroglobulinemia, Marginal Zone Lymphoma and Chronic Lymphocytic Leukemia/Small Lymphocytic. Clinical coverage criteria updated for other B-Cell Lymphomas. Updated background and references.
10/2022	Annual review. Updates made to B-Cell Lymphoma and CLL/SLL criteria based on NCCN recommendations. Updated background and reference. Added state mandate footnote.
10/2023	Annual review. Updates made to B-Cell Lymphoma criteria based on NCCN recommendations. Updated background and reference.
7/2024	Annual review. Clinical coverage criteria added for follicular lymphoma and hairy cell leukemia. Updated B-cell lymphoma formatting. Updated background and reference.
7/2025	Annual review with no changes to criteria. Updated background and references.
2/2026	Annual review. Added coverage for progressive FL and primary CNS lymphoma. Updated background and references.