

Lymphoma, Marginal Zone Pathways**

Patient Name: _____ Date of Birth: _____

Member ID: _____ Treatment Start Date: _____

Stage: _____ Pathology: _____

ECOG Status: 1 2 3 4 ICD-10 Code: _____

Line of Therapy: 1st Line 2nd Line 3rd Line /+ Maint.

Biomarkers/Attributes: (select all that apply)

HIV Associated Lymphoma: <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B Status: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Transplant Candidate: <input type="checkbox"/> Yes <input type="checkbox"/> No	CD20 Status: <input type="checkbox"/> Negative <input type="checkbox"/> Positive

Marginal Zone Lymphoma

First Line

- Helicobacter pylori* (H. pylori) eradication therapy (Gastric MALT lymphoma only)
- Bendamustine + Rituximab* (BR)
- Chlorambucil ± Rituximab*
- Rituximab* (weekly for 4 doses)

Second and Subsequent Lines of Therapy (non-refractory disease)

- Bendamustine + Rituximab* (BR)
- CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + Rituximab*
- CVP (cyclophosphamide, vincristine, prednisone) + Rituximab*
- Chlorambucil ± Rituximab*
- Rituximab* (weekly for 4 doses)

Second and Subsequent Lines of Therapy (refractory disease)

- Bendamustine + Obinutuzumab
- Bendamustine + Rituximab* (BR)
- CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + Rituximab*
- CVP (cyclophosphamide, vincristine, prednisone) + Rituximab*
- Chlorambucil ± Rituximab*
- Rituximab* (weekly for 4 doses)

Marginal Zone Lymphoma, High-Grade (Grade 3)**

First Line

- Rituximab*-CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone)

Second and Subsequent Lines of Therapy

- Rituximab* ± GDP (gemcitabine, dexamethasone, cisplatin or carboplatin)
- Rituximab* ± ICE (ifosfamide, carboplatin, etoposide)
- Rituximab* ± DHAP (dexamethasone, cisplatin, cytarabine)

Note: Pathways are independent of specific Optum Care/health plan medical policy coverage criteria. Optum Care/health plan medical policy/clinical guidelines should be consulted to determine whether proposed services will be covered. Biosimilars or alternate formulations (along with the reference products) are considered on pathway unless otherwise specified by health plan formularies, medical policies, or preferred product rules.

*a biosimilar agent may be preferred under the patient's specific health plan

**Therapies that are administered at Centers of Excellence, including stem cell transplant or CAR T-cell therapy, are not included in pathways. Patients eligible for transplant or CAR T-cell therapy should be referred appropriately for evaluation.

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