Ziv-aflibercept (Zaltrap®)	Place of Service Office Administration Outpatient Facility Infusion Administration Infusion Center Administration HCPCS: J9400 per 1 mg

Condition(s) listed in policy (*see criteria for details*)

- Colorectal cancer

AHFS therapeutic class: Antineoplastic agent

Mechanism of action: Vascular Endothelial Growth Factor

(1) Special Instructions and Pertinent Information

Covered under the Medical Benefit, please submit clinical information for prior authorization review.

(2) Prior Authorization/Medical Review is required for the following condition(s)

All requests for Zaltrap® (ziv-aflibercept) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

Colorectal cancer

1. Either of the following:
    a. Advanced or metastatic colorectal cancer and all the following:
        i. Patient has progressed on or after prior systemic treatment for advanced or metastatic disease, AND
        ii. Patient has not received a prior irinotecan-containing regimen, AND
        iii. Being used as subsequent therapy only in combination with FOLFIRI (leucovorin, fluorouracil, irinotecan) OR only in combination with irinotecan, AND
        iv. Patient is unable to undergo treatment with FOLFIRI plus bevacizumab, or another bevacizumab-containing regimen (e.g., irinotecan plus bevacizumab)

    OR

    b. Metachronous metastatic colorectal cancer and all the following:
        i. Patient has received prior adjuvant treatment with FOLFOX or CapeOx, AND
        ii. Being used only in combination with FOLFIRI (leucovorin, fluorouracil, irinotecan) OR in combination with irinotecan, AND
        iii. Patient is unable to undergo treatment with FOLFIRI plus bevacizumab, or another bevacizumab-containing regimen (e.g., irinotecan plus bevacizumab)

Covered Doses
Up to 4 mg/kg IV every 2 weeks

Coverage Period
Cover yearly, based on continued response

ICD-10:
Colon: C17.0-C17.2, C17.8, C17.9, C18.0-C18.9, C78.00-C78.02, C78.6, C78.7, Z85.038, Z85.068
Rectal: C19, C20, C21.8, C78.00-C78.02, C78.7

(3) The following condition(s) DO NOT require Prior Authorization/Preservice

All requests for Zaltrap® (ziv-aflibercept) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT medically necessary for the following condition(s)

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information

How supplied:

- 100 mg (single-use vial)
- 200 mg (single-use vial)

(6) References

- AHFS®. Available by subscription at http://www.lexi.com

- DrugDex®. Available by subscription at http://www.micromedexsolutions.com
- National Comprehensive Cancer Network. Colon Cancer (Version 2.2023). Available at http://www.nccn.org.
- National Comprehensive Cancer Network. Rectal Cancer (Version 3.2023). Available at http://www.nccn.org.
- Zaltrap® (ziv-afibercept) [Prescribing information]. Bridgewater, NJ: Regeneron Pharmaceuticals/sanofi-aventis U.S. LLC; 12/2020.

(7) Policy Update

Date of last review: 3Q2023
Date of next review: 3Q2024
Changes from previous policy version:

- No clinical change to policy following routine annual review.

BSC Drug Coverage Criteria to Determine Medical Necessity
Reviewed by P&T Committee