POLICY: Oncology (Injectable) – Zaltrap

- Zaltrap® (ziv-aflibercept intravenous infusion – Regeneron/Sanofi-Aventis)

EFFECTIVE DATE: 1/1/2021
LAST REVISION DATE: 09/16/2024

COVERAGE CRITERIA FOR: All Aspirus Medicare Plans

OVERVIEW

Zaltrap, a recombinant fusion protein, in combination with FOLFIRI (5-fluorouracil [5-FU], leucovorin, and irinotecan), is indicated for patients with **metastatic colorectal cancer** that is resistant to or has progressed following an oxaliplatin-containing regimen.[1]

Guidelines

The National Comprehensive Cancer Network **colon cancer** guidelines (version 3.2023 – September 21, 2023) and **rectal cancer** guidelines (version 5.2023 – September 21, 2023) recommend Zaltrap as:[2-4]

- Initial treatment for patients with unresectable metachronous metastases and previous FOLFOX (5-FU, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin) regimens within the past 12 months in combination with irinotecan OR with FOLFIRI, or
- Subsequent therapy after first progression of unresectable advanced or metastatic disease in combination with irinotecan or with FOLFIRI for disease not previously treated with an irinotecan-based regimen.

Both of these uses have a category 2A recommendation. Zaltrap has a category 2B recommendation for use as adjuvant therapy, in combination with FOLFIRI or irinotecan, for unresectable metachronous metastases that convert to resectable disease after primary treatment.

POLICY STATEMENT

Prior Authorization is recommended for medical benefit coverage of Zaltrap. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indication. 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. Because of the specialized skills required for evaluation and diagnosis of patients treated with Zaltrap, as well as the monitoring required for adverse events and long-term efficacy, approval requires Zaltrap to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

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

FDA-Approved Indication

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1. **Colon and Rectal Cancer, Appendiceal Adenocarcinoma.** Approve for 1 year if the patient meets the following (A, B, C, D, E, and F):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has advanced or metastatic disease; AND
   - **C)** Patient has been previously treated with an oxaliplatin- or fluoropyrimidine-containing regimen; AND
     Note: Fluoropyrimidines include 5-fluorouracil (5-FU) and capecitabine.
   - **D)** Patient has not previously been treated with FOLFIRI; AND
     Note: FOLFIRI includes 5-fluorouracil (5-FU), leucovorin, and irinotecan.
   - **E)** Zaltrap will be used in combination with 5-fluorouracil (5-FU) or capecitabine, and/or irinotecan; AND
   - **F)** The medication is prescribed by or in consultation with an oncologist.

   Dosing. Approve up to 4 mg/kg administered by intravenous infusion no more frequently than once every 2 weeks.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Zaltrap 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

1. Zaltrap® intravenous infusion [prescribing information]. Bridgewater, NJ: Regeneron/Sanofi-Aventis; June 2020.
2. The NCCN Colon Cancer Clinical Practice Guidelines in Oncology (version 3.2023 – September 21, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on October 5, 2023.
3. The NCCN Rectal Cancer Clinical Practice Guidelines in Oncology (version 5.2023 – September 21, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on October 5, 2023.

4. The NCCN Drugs and Biologics Compendium. © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on October 5, 2023. Search term: ziv-aflibercept.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	10/19/2022
Annual Revision	**Colon and Rectal Cancer, Appendiceal Adenocarcinoma:** Appendiceal Adenocarcinoma was added to the condition of approval.	10/11/2023
Aspirus P&T Review	Policy reviewed and approved by Aspirus P&T committee. Annual review process	09/16/2024