



PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Injectable) – Zaltrap Prior Authorization Policy

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

REVIEW DATE: 10/13/2021

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 (NCCN) colon cancer guidelines (version 3.2021 – September 10, 2021)² and rectal cancer guidelines (version 2.2021 – September 10, 2021)³ recommend Zaltrap as 1) primary treatment for patients with unresectable metachronous metastases and previous adjuvant 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 2) 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.²⁻⁴ Both of these uses have a category 2A recommendation. In patients with advanced or metastatic disease, Zaltrap is not listed as an option for initial therapy. 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 prescription benefit coverage of Zaltrap. 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

1. **Colon and Rectal Cancer.** Approve for 1 year if the patient meets the following criteria (A, B, C, D, E, and F):
 - A) Patient is \geq 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.

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 3.2021 – September 10, 2021). © 2021 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on October 11, 2021.
3. The NCCN Rectal Cancer Clinical Practice Guidelines in Oncology (version 2.2021 – September 10, 2021). © 2021 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on October 11, 2021.
4. The NCCN Drugs and Biologics Compendium. © 2021 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on October 11, 2021. Search term: ziv-aflibercept.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	09/23/2020
Annual Revision	Colon and Rectal Cancer: A requirement was added that the patient is \geq 18 years of age.	10/13/2021

Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. *We* do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:

Provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If *you* need these services, contact *us* at the phone number shown on the inside cover of this *contract*, *your* id card, or aspirushealthplan.com.

If *you* believe that *we* have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, *you* can file a grievance with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1.866.631.5404 (TTY: 711)
Fax: 763.847.4010
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If *you* need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.866.631.5404 (TTY: 711).

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلى رقم الهاتف 1.866.631.5404 (رقم هاتف الصم والبك : 711)

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

Hindi: _यान द_ : य_द आप िहंदी बोलते ह_ तो आपके िलए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_। 1.866.631.5404 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.866.631.5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

Traditional Chinese: 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1.866.631.5404 (TTY:711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzsch, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

Lao: ໄປ່ດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.866.631.5404 (TTY:711).