Clinical Policy: Zolbetuximab-clzb (Vyloy)

Reference Number: CP.PHAR.705
Effective Date: 01.01.25
Last Review Date: 12.24
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Zolbetuximab-clzb (Vyloy®) is a claudin (CLDN) 18.2-directed cytolytic antibody.

FDA Approved Indication(s)

Vyloy is indicated in combination with fluoropyrimidine- and platinum-containing chemotherapy for the first-line treatment of adults with locally advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-negative gastric or gastroesophageal junction adenocarcinoma whose tumors are CLDN 18.2 positive as determined by an FDA-approved test.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Vyloy is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Gastric or Gastroesophageal Junction Adenocarcinoma (must meet all)**:**

1. Diagnosis of gastric or gastroesophageal junction adenocarcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is locally advanced unresectable or metastatic;
5. Disease is HER2-negative;
6. Tumor is CLDN 18.2 positive;
7. Request is for first-line treatment;
8. Vyloy is prescribed in combination with both of the following (a and b):
   a. Fluoropyrimidine (e.g., capecitabine, fluorouracil)-containing chemotherapy;
   b. Platinum (e.g., oxaliplatin)-containing chemotherapy;
9. Request meets one of the following (a or b):*
   a. Dose does not exceed an initial 800 mg/m^2 dose followed by either 600 mg/m^2 every 3 weeks or 400 mg/m^2 every 2 weeks;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy.

A. Gastric or Gastroesophageal Junction Adenocarcinoma (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Vyloy for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 600 mg/m^2 every 3 weeks or 400 mg/m^2 every 2 weeks;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND

criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
CLDN: claudin
FDA: Food and Drug Administration
HER2: human epidermal growth factor receptor 2

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Gastric or gastroesophageal junction adenocarcinoma	First dose: 800 mg/m^2 IV Subsequent doses: • 600 mg/m^2 IV every 3 weeks, or • 400 mg/m^2 IV every 2 weeks	See dosing regimen

VI. Product Availability

Lyophilized powder in single-dose vial: 100 mg

VII. References

1. Vyloy Prescribing Information. Northbrook, IL: Astellas Pharma US, Inc.; October 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761365s000lbl.pdf. Accessed October 28, 2024.
2. Shitara K, Lordick F, Bang YJ, et al. Zolbetuximab plus mFOLFOX6 in patients with CLDN18.2-positive, HER2-negative, untreated, locally advanced unresectable or metastatic gastric or gastro-oesophageal junction adenocarcinoma (SPOTLIGHT): a multicentre, randomised, double-blind, phase 3 trial. Lancet. 2023 May 20; 401(10389): 1655-1668.
3. Shah MA, Shitara K, Ajani JA, et al. Zolbetuximab plus CAPOX in CLDN18.2-positive gastric or gastroesophageal junction adenocarcinoma: the randomized, phase 3 GLOW trial. Nat Med. 2023 Aug; 29(8): 2133-2141.

4. National Comprehensive Cancer Network. Esophageal and Esophagogastric Junction Cancers Version 4.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/esophageal.pdf. Accessed October 29, 2024.
5. National Comprehensive Cancer Network. Gastric Cancer Version 4.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/gastric.pdf. Accessed October 29, 2024.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
C9303	Injection, zolbetuximab-clzb, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	10.28.24	12.24
HCPCS code added [C9303], removed codes [J9999, C9399].	04.02.25	

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to

applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.