Clinical Policy: Lurbinectedin (Zepzelca)

Reference Number: LA.PHAR.500
Effective Date: 09.29.23
Last Review Date: 07.18.26
Line of Business: Medicaid

Coding Implications
Revision Log

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

****Please note: This policy is for medical benefit****

Description
Lurbinectedin (Zepzelca®) is an alkylating drug.

FDA Approved Indication(s)
Zepzelca is indicated:

- In combination with atezolizumab or atezolizumab and hyaluronidase-tqjs, for the maintenance treatment of adult patients with extensive-stage small cell lung cancer (SCLC) whose disease has not progressed after first-line induction therapy with atezolizumab or atezolizumab and hyaluronidase-tqjs, carboplatin and etoposide
- For the treatment of adult patients with metastatic SCLC with disease progression on or after platinum-based chemotherapy.*

* This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

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

It is the policy of Louisiana Healthcare Connections® that Zepzelca is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Small Cell Lung Cancer (must meet all)**:**

1. Diagnosis of SCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed in one of the following ways (a or b):
   a. Both of the following (i and ii):
      i. As single-agent therapy;
      ii. Disease is advanced or metastatic and has progressed on or after platinum-containing regimen (e.g., cisplatin, carboplatin);

b. For extensive-stage SCLC: In combination with Tecentriq® or Tecentriq Hybreza™ for maintenance therapy following combination use with Tecentriq or Tecentriq Hybreza, carboplatin and etoposide;

5. Request meets one of the following (a or b):*
   a. Dose does not exceed 3.2 mg/m^2 every 21 days;
   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: 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 LA.PMN.255.
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 LA.PMN.53.

II. Continued Therapy

A. Small Cell Lung Cancer (must meet all)**:**

1. Currently receiving medication via Louisiana Healthcare Connections benefit, or documentation supports that member is currently receiving Zepzelca for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Prescribed as single-agent therapy;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 3.2 mg/m^2 every 21 days;
   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 LA.PMN.255.
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 LA.PMN.53.

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 policy LA.PMN.53.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
SCLC: small cell lung cancer

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
cisplatin- or carboplatin-containing chemotherapy	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
SCLC	3.2 mg/m^2 IV every 21 days	3.2 mg/m^2 per 21 days

VI. Product Availability

Single-dose vial: 4 mg

VII. References

1. Zepzelca Prescribing Information. Palo Alto, CA: Jazz Pharmaceuticals, Inc.; October 2025. Available at: https://www.zepzelca.com. Accessed December 2, 2025.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org. Accessed December 2, 2025.
3. National Comprehensive Cancer Network. Small Cell Lung Cancer Version 2.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/sclc.pdf. Accessed December 2, 2025.

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
J9223	Injection, lurbinectedin, 0.1 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Policy created	05.01.23	08.28.23
Added monotherapy requirement per NCCN; references reviewed and updated.	02.01.24	05.10.24
Annual review; references reviewed and updated.	09.16.24	01.02.25
Annual review: no significant changes; references reviewed and updated.	08.18.25	N/A, no material revisions
Added option for combination use with Tecentriq or Tecentriq Hybreza following combination use with Tecentriq or Tecentriq Hybreza, carboplatin and etoposide for extensive-stage SCLC per prescribing information; extended initial approval duration from 6 to 12 months.	07.18.26	10.07.26

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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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.

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