Clinical Policy: Zenocutuzumab-zbco (Bizengri)

Reference Number: LA.PHAR.713
Effective Date:
Last Review Date: 03.04.25
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

Zenocutuzumab-zbco (Bizengri®) is a bispecific human epidermal growth factor receptor 2 (HER2)- and HER3-directed antibody.

FDA Approved Indication(s)

Bizengri is indicated for the treatment of:

- Adults with advanced, unresectable, or metastatic non-small cell lung cancer (NSCLC) harboring a neuregulin 1 (NRG1) gene fusion with disease progression on or after prior systemic therapy.*
- Adults with advanced, unresectable, or metastatic pancreatic adenocarcinoma harboring a NRG1 gene fusion with disease progression on or after prior systemic therapy.*

**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 (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 Bizengri is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of advanced, unresectable, or metastatic NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is positive for NRG1 gene fusion;
5. Failure of at least one prior systemic therapy (*see Appendix B for examples*);
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 750 mg 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. Pancreatic Adenocarcinoma (must meet all)**:**
1. Diagnosis of advanced, unresectable, or metastatic pancreatic adenocarcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is positive for NRG1 gene fusion;
5. Failure of at least one prior systemic therapy (*see Appendix B for examples*);
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 750 mg 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

C. 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. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Louisiana Healthcare Connections, or documentation supports that member is currently receiving Bizengri 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 750 mg 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 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
HER2: human epidermal growth factor receptor 2
HER3: human epidermal growth factor receptor 3
NCCN: National Comprehensive Cancer Network
NRG1: neuregulin 1
NSCLC: non-small cell lung cancer
PD-1: programmed death protein 1
PD-L1: programmed death-ligand 1

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
Examples of NSCLC systemic therapy components: • platinum chemotherapy (e.g., carboplatin, cisplatin) • anti-PD-1/PD-L1 therapy (e.g., Keytruda®, Libtayo®, Opdivo®, Imfinzi®, Tecentriq®) • bevacizumab (Avastin®, Alymsys®, Avzivi®, Mvasi®, Vegzelma™, and Zirabev™) • gemcitabine • taxane chemotherapy (e.g., paclitaxel, docetaxel)	Varies	Varies
Examples of pancreatic adenocarcinoma systemic therapy: • FOLFIRINOX (fluorouracil + leucovorin + irinotecan + oxaliplatin) • NALIRIFOX (liposomal irinotecan + fluorouracil + leucovorin + oxaliplatin) • gemcitabine-based therapy	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
• capecitabine-based therapy • taxane-based chemotherapy (e.g., albumin-bound paclitaxel)		

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

- Contraindication(s): none reported
- Boxed warning(s): embryo-fetal toxicity

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
NSCLC, pancreatic adenocarcinoma	750 mg IV every 2 weeks	750 mg/2 weeks

VI. Product Availability

Single-dose vial: 375 mg/18.75 mL (2 vials/carton)

VII. References

1. Bizengri Prescribing Information. Cambridge, MA: Merus US, Inc.; December 2024. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/761352s001lbl.pdf. Accessed December 10, 2024.
2. National Comprehensive Cancer Network Guidelines. Non-Small Cell Lung Cancer Version 11.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed December 10, 2024.
3. National Comprehensive Cancer Network Guidelines. Pancreatic Adenocarcinoma Version 3.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/pancreatic.pdf. Accessed December 10, 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
J3590	Unclassified biologics
C9399	Unclassified drugs or biologicals

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted to local policy.	03.04.25	

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. 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.

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 LHCC.