



Zanidatamab-hrii (Ziihera®)

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

HER2- POSITIVE BILIARY TRACT CANCER

Ziihera is indicated for the treatment of adults with previously treated, unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-positive immunohistochemistry (IHC 3+) biliary tract cancer (BTC), as detected by an FDA-approved test.

Compendial Uses

- HER2-positive biliary tract cancer

All other indications are considered experimental/investigational and not medically necessary.

DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review: human epidermal growth factor receptor 2 (HER2) status (e.g., immunohistochemistry (IHC) score).

COVERAGE CRITERIA

Biliary Tract Cancer

Authorization of 12 months may be granted for subsequent treatment of unresectable or resected gross residual (R2) disease or metastatic HER2-positive (IHC 3+) biliary tract cancer (intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma, or gallbladder cancer) when used as a single agent.

CONTINUATION OF THERAPY



Medical Policy Manual

Approved New: Do Not Implement until 3/4/25

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

1. Ziihera [package insert]. Palo Alto, CA: Jazz Pharmaceuticals, Inc.; November 2024.
2. The NCCN Drugs & Biologics Compendium® © 2024 National Comprehensive Cancer Network, Inc. <https://www.nccn.org>. Accessed November 27, 2024.

EFFECTIVE DATE 3/4/2025

ID_CHS