# Clinical Policy: Ziv-Aflibercept (Zaltrap)

Reference Number: CP.PHAR.325
Effective Date: 03.01.17
Last Review Date: 11.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

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

## Description

Ziv-aflibercept (Zaltrap®) is a vascular endothelial growth factor (VEGF) inhibitor.

## FDA Approved Indication(s)

Zaltrap, in combination with 5-fluorouracil, leucovorin, irinotecan (FOLFIRI), is indicated for patients with metastatic colorectal cancer (CRC) that is resistant to or has progressed following an oxaliplatin-containing regimen.

## 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 Zaltrap is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. Colorectal Cancer** (must meet all)**:**

1. Diagnosis of advanced, unresectable, or metastatic CRC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Previous treatment with one of the following (a, b, or c):
   a. An oxaliplatin-containing regimen (e.g., FOLFOX, CapeOX);
   b. A 5-fluorouracil and leucovorin-containing regimen (off-label);
   c. A capecitabine-containing regimen (off-label);
5. Prescribed in combination with irinotecan or FOLFIRI;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 4 mg/kg 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:**
**Medicaid/HIM/ICHRA** – 12 months
**Commercial** – 6 months or to the member's renewal date, whichever is longer

**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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, and CP.PMN.53 for Medicaid.

## II. Continued Therapy

**A. Colorectal Cancer** (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Zaltrap 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 4 mg/kg 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:**
**Medicaid/HIM/ICHRA** – 12 months
**Commercial** – 6 months or to the member's renewal date, whichever is longer

**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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, 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/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

CapeOX: capecitabine and oxaliplatin
CRC: colorectal cancer
FDA: Food and Drug Administration
FOLFIRI: fluorouracil, leucovorin, irinotecan
FOLFOX: fluorouracil, leucovorin, oxaliplatin
VEGF: vascular endothelial growth factor

*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 |
|---|---|---|
| Modified FOLFOX 6 | Day 1: oxaliplatin 85 mg/m$^2$ IV<br>Day 1: Folinic acid 400 mg/m$^2$ IV<br>Days 1–3: 5-FU 400 mg/m$^2$ IV bolus on day 1, then 1,200 mg/m$^2$/day × 2 days (total 2,400 mg/m$^2$ over 46–48 hours) IV continuous infusion.<br>Repeat cycle every 2 weeks. | See dosing regimen |
| CapeOX | Day 1: Oxaliplatin 130 mg/m$^2$ IV<br>Days 1–14: Capecitabine 1,000 mg/m$^2$ PO BID.<br>Repeat cycle every 3 weeks. | See dosing regimen |
| FOLFIRI | Day 1: Irinotecan 180 mg/m$^2$ IV<br>Day 1: Leucovorin 400 mg/m$^2$ IV<br>Day 1: Fluorouracil 400 mg/m$^2$ IV followed by 2400 mg/m$^2$ continuous IV over 46 hours<br>Repeat cycle every 14 days. | See dosing regimen |
| 5-fluorouracil and leucovorin | Roswell Park regimen:<br>Leucovorin 500 mg/m$^2$ IV followed by 5-FU 500 mg/m$^2$ IV bolus one hour after start of leucovorin on days 1, 8, 15, 22, 29, 36. Repeat every 8 weeks. | See dosing regimen |

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| | Biweekly regimen:<br>Leucovorin 400 mg/m$^2$ IV on day one followed by 5-FU 400 mg/m$^2$ IV bolus then 1,200 mg/m$^2$ continuous IV. Repeat every 2 weeks.<br><br>Weekly regimen:<br>Leucovorin 20 mg/m$^2$ IV on day one followed 5-FU 500 mg/m$^2$ IV bolus one hour after start of leucovorin. Alternatively 5-FU 2,600 mg/m$^2$ continuous IV with leucovorin 500 mg/m$^2$ IV. Repeat weekly. | |
| capecitabine | 850 – 1,250 mg/m$^2$ PO BID on days 1-14. Repeat every 3 weeks. | 2,500 mg/m$^2$/day |

*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 |
|---|---|---|
| CRC | 4 mg/kg IV over 1 hour every two weeks | 4 mg/kg |

## VI. Product Availability

Single-use vials for injection: 100 mg/4 mL, 200 mg/8 mL

## VII. References

1. Zaltrap Prescribing Information. Bridgewater, NJ: Sanofi-Aventis U.S., LLC; May 2025. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/125418s054lbl.pdf. Accessed August 4, 2026.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed August 4, 2026.
3. National Comprehensive Cancer Network. Colon Cancer Version 2.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf. Accessed August 4, 2026.
4. National Comprehensive Cancer Network. Rectal Cancer Version 2.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/rectal.pdf. Accessed August 4, 2026.

## 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 |
|---|---|
| J9400 | Injection, ziv-aflibercept, 1 mg |

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| 4Q 2022 annual review: added diagnosis qualifier that CRC is advanced, unresectable, or metastatic per NCCN; references reviewed and updated. Template changes applied to other diagnoses/indications. | 08.05.22 | 11.22 |
| 4Q 2023 annual review: no significant changes; references reviewed and updated. | 08.15.23 | 11.23 |
| 4Q 2024 annual review: no significant changes; references reviewed and updated. | 08.05.24 | 11.24 |
| 4Q 2025 annual review: extended initial approval duration for HIM/Medicaid from 6 to 12 months; references reviewed and updated. | 07.15.25 | 11.25 |
| 4Q 2026 annual review: added ICHRA line of business; references reviewed and updated. | 08.04.26 | 11.26 |

**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. 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.

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**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.

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