CARECONTINUUM™

UTILIZATION MANAGEMENT MEDICAL POLICY

POLICY: Oncology (Injectable) – Vyloy Utilization Management Medical Policy
- Vyloy® (zolbetuximab-clzb intravenous infusion – Astellas)

REVIEW DATE: 10/30/2024; selected revision 01/22/2025

OVERVIEW

Vyloy, a claudin 18.2-directed cytolytic antibody, is indicated in combination with fluoropyrimidine- and platinum-containing chemotherapy for the first-line treatment of locally advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-negative gastric or gastrointestinal junction adenocarcinoma in adults in whose tumors are claudin 18.2 (CLDN18.2)-positive as determined by an FDA-approved test.[1]

Dosing Information

The recommended first dose of Vyloy is 800 mg/m^2 administered by intravenous (IV) infusion.[1] Subsequent doses are either 600 mg/m^2 administered by IV infusion once every 3 weeks, or 400 mg/m^2 administered by IV infusion once every 2 weeks. Treatment can continue until disease progression or unacceptable adverse events.

Guidelines

The National Comprehensive Cancer Network has addressed Vyloy in the following guidelines:

- **Esophageal and Esophagogastric Junction Cancers** (version 5.2024 – December 20, 2024) clinical practice guidelines recommend Vyloy as a "Preferred Regimen" for the treatment of HER2-negative, CLDN18.2-positive unresectable locally advanced, recurrent, or metastatic esophageal adenocarcinoma (category 2A) and esophagogastric junction adenocarcinoma (category 1) in combination with fluorouracil or capecitabine and oxaliplatin.[2,3]
- **Gastric Cancer** (version 5. 2024 – December 20, 2024) clinical practice guidelines recommend Vyloy as a "Preferred Regimen" for the treatment of HER2-negative, CLDN18.2-positive unresectable locally advanced, recurrent, or metastatic gastric cancer (category 2A) in combination with fluorouracil or capecitabine and oxaliplatin.[2,4]

POLICY STATEMENT

Prior Authorization is recommended for medical benefit coverage of Vyloy. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indications. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Vyloy as well as the monitoring required for adverse events and long-term efficacy, approval requires Vyloy to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

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Coverage of Vyloy is recommended in those who meet one of the following criteria:

FDA-Approved Indication

1. **Gastric or Gastroesophageal Junction Adenocarcinoma.** Approve for 1 year if the patient meets ALL of the following (A, B, C, D, E, F, and G):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has unresectable locally advanced, recurrent, or metastatic disease; AND
   - **C)** Tumor is claudin 18.2 positive as determined by an approved test; AND
     Note: Claudin 18.2 positivity is defined as ≥ 75% of tumor cells demonstrating moderate to strong membranous claudin 18.2 immunohistochemical staining.
   - **D)** Tumor is human epidermal growth factor receptor 2 (HER2)-negative; AND
   - **E)** Medication is used for first-line treatment; AND
   - **F)** Medication is used in combination with fluoropyrimidine- and platinum-containing chemotherapy; AND
     Note: Examples of fluoropyrimidines include 5-fluorouracil and capecitabine. Examples of platinum chemotherapy agents include oxaliplatin.
   - **G)** Medication is prescribed by or consultation with an oncologist.

   Dosing. Approve BOTH of the following dosing regimens (A and B):
   - **A)** First dose: Approve 800 mg/m^2 administered by intravenous infusion; AND
   - **B)** Subsequent doses: Approve ONE of the following dosing regimens (i or ii):
     - **i.** Approve 600 mg/m^2 administered by intravenous infusion no more frequently than once every 3 weeks; OR
     - **ii.** Approve 400 mg/m^2 administered by intravenous infusion no more frequently than once every 2 weeks.

Other Uses with Supportive Evidence

2. **Esophageal Adenocarcinoma.** Approve for 1 year if the patient meets ALL of the following (A, B, C, D, E, F, and G):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has unresectable locally advanced, recurrent, or metastatic disease; AND
   - **C)** Tumor is claudin 18.2 positive as determined by an approved test; AND
     Note: Claudin 18.2 positivity is defined as ≥ 75% of tumor cells demonstrating moderate to strong membranous claudin 18.2 immunohistochemical staining.
   - **D)** Tumor is human epidermal growth factor receptor 2 (HER2)-negative; AND
   - **E)** Medication is used for first-line treatment; AND
   - **F)** Medication is used in combination with fluoropyrimidine- and platinum-containing chemotherapy; AND
     Note: Examples of fluoropyrimidines include 5-fluorouracil and capecitabine. Examples of platinum chemotherapy agents include oxaliplatin.
   - **G)** Medication is prescribed by or consultation with an oncologist.

   Dosing. Approve BOTH of the following dosing regimens (A and B):
   - **A)** First dose: Approve 800 mg/m^2 administered by intravenous infusion; AND
   - **B)** Subsequent doses: Approve ONE of the following dosing regimens (i or ii):
     - **i.** Approve 600 mg/m^2 administered by intravenous infusion no more frequently than once every 3 weeks; OR

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ii. Approve 400 mg/m^2 administered by intravenous infusion no more frequently than once every 2 weeks.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Vyloy is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Vyloy intravenous infusion [prescribing information]. Northbrook, IL: Astellas; October 2024.
2. The NCCN Drugs and Biologics Compendium. © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on January 17, 2025. Search term: thiotepa
3. The NCCN Esophageal and Esophagogastric Junction Cancers Clinical Practice Guidelines in Oncology (version 5.2024 – December 20, 2024). © 2024 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed on January 17, 2025.
4. The NCCN Gastric Cancer Clinical Practice Guidelines in Oncology (version 5.2024 – December 20, 2024). © 2024 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed on January 17, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	10/30/2024
Selected Revision	**Gastric or Gastroesophageal Junction Adenocarcinoma:** Added descriptor "recurrent" to requirement that the patient has unresectable locally advanced, recurrent, or metastatic disease. **Esophageal Adenocarcinoma:** Added new condition of approval.	01/22/2025

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