

## Medical Policy Manual

**Draft Revision Policy: Do Not Implement**

### Zenocutuzumab-zbco (Bizengri®)

#### 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.

**The proposal is to add text/statements in red and to delete text/statements with strikethrough:  
POLICY**

#### 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 Indications

- 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.

##### Compendial Uses

- Recurrent NSCLC
- Recurrent Pancreatic Adenocarcinoma
- Biliary Tract Cancers

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: neuregulin 1 (NRG1) gene fusion status.

#### COVERAGE CRITERIA

##### Non-Small Cell Lung Cancer (NSCLC)

Authorization of 12 months may be granted for treatment of advanced unresectable, ~~or~~ metastatic, **or recurrent** NSCLC when **all** ~~both~~ of the following criteria are met:

- Member has experienced disease progression on or after prior systemic therapy. ~~AND~~
- Member has neuregulin 1 (NRG1) gene fusion positive disease.
- **The requested medication will be used as a single agent.**

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### Pancreatic Adenocarcinoma

Authorization of 12 months may be granted for treatment of advanced unresectable, ~~or~~ metastatic, **or recurrent** pancreatic adenocarcinoma when **all both** of the following criteria are met:

- Member has experienced disease progression on or after prior systemic therapy. ~~AND~~
- Member has neuregulin 1 (NRG1) gene fusion positive disease.
- **The requested medication will be used as a single agent.**

### Biliary Tract Cancers

Authorization of 12 months may be granted for treatment of unresectable, gross residual (R2), or metastatic biliary tract cancer (including intrahepatic and extrahepatic cholangiocarcinoma) when all of the following criteria are met:

- Member has experienced disease progression on or after prior systemic therapy.
- Member has neuregulin 1 (NRG1) gene fusion positive disease.
- **The requested medication will be used as a single agent.**

### CONTINUATION OF THERAPY

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. Bizengri [package insert]. Cambridge, MA: Merus US, Inc.; **March 2025.**
2. **The NCCN Drugs & Biologics Compendium® © 2026 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed March 24, 2026.**

### EFFECTIVE DATE

ID\_CHS\_2026a



BlueCross BlueShield  
of Tennessee

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