

# **Evolent Clinical Guideline 3153 for Zusduri™ (mitomycin intravesical solution)**

<b>Guideline Number:</b> Evolent_CG_3153	<b><u>Applicable Codes</u></b>	
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## STATEMENT

### Purpose

To define and describe the accepted indications for Zsduri (mitomycin intravesical solution) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

Evolent is responsible for processing all medication requests from network ordering providers. Medications not authorized by Evolent may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

## INDICATIONS

**Continuation requests for a not-approvable medication shall be exempt from this Evolent policy provided**

- The member has not experienced disease progression on the requested medication AND
- The requested medication was used within the last year without a lapse of more than 30 days of having an active authorization AND
- Additional medication(s) are not being added to the continuation request.

### Bladder Cancer

- Zsduri (mitomycin intravesical solution) may be used in adult members with recurrent low-grade intermediate-risk non-muscle invasive bladder cancer (LG-IR-NMIBC).

## CONTRAINDICATIONS/WARNINGS

- Contraindications
  - Perforation of the bladder
  - Hypersensitivity to mitomycin or any component of the formulation

## EXCLUSION CRITERIA

- Disease progression while taking Zsduri (mitomycin intravesical solution).
- Concurrent use with other chemotherapy.
- Dosing exceeds single dose limit of Zsduri (mitomycin intravesical solution) 75 mg.

- Treatment exceeds maximum duration limit of 6 total doses (dose given weekly).
- Investigational use of Zusduri (mitomycin intravesical solution) with an off-label indication that is not sufficient in evidence or is not generally accepted by the medical community. Sufficient evidence that is not supported by CMS recognized compendia or acceptable peer reviewed literature is defined as any of the following:
  - Whether the clinical characteristics of the patient and the cancer are adequately represented in the published evidence.
  - Whether the administered chemotherapy/biologic therapy/immune therapy/targeted therapy/other oncologic therapy regimen is adequately represented in the published evidence.
  - Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients. Generally, the definitions of Clinically Meaningful outcomes are those recommended by ASCO, e.g., Hazard Ratio of < 0.80 and the recommended survival benefit for OS and PFS should be at least 3 months.
  - Whether the experimental design, considering the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover).
  - That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.
  - That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
  - That abstracts (including meeting abstracts) without the full article from the approved peer-reviewed journals lack supporting clinical evidence for determining accepted uses of drugs.

## CODING AND STANDARDS

### Codes

- J9999 - mitomycin solution, intravesical

### Applicable Lines of Business

<input type="checkbox"/>	CHIP (Children's Health Insurance Program)
<input checked="" type="checkbox"/>	Commercial
<input checked="" type="checkbox"/>	Exchange/Marketplace
<input checked="" type="checkbox"/>	Medicaid
<input type="checkbox"/>	Medicare Advantage

## POLICY HISTORY

Date	Summary
July 2025	<ul style="list-style-type: none"><li>• New policy</li></ul>

## LEGAL AND COMPLIANCE

### Guideline Approval

#### Committee

Reviewed / Approved by Evolent Specialty Clinical Guideline Review Committee

### Disclaimer

*Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.*

## REFERENCES

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5. National Comprehensive Cancer Network. Cancer Guidelines and Drugs and Biologics Compendium 2025.
6. AHFS Drug Information. American Society of Health-Systems Pharmacists or Wolters Kluwer Lexi-Drugs. Bethesda, MD 2025.
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<http://www.accessdata.fda.gov/scripts/drugshortages/default.cfm>.