Pharmacy Medical Necessity Guidelines: Trastuzumab Products (Herceptin®, Herceptin Hylecta™, Phesgo™)

Effective: October 1, 2020

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	
Pharmacy (RX) or Medical (MED) Benefit	MED / RX	Department to Review	PRECERT /MM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☒ Tufts Health Plan Commercial products – large group plans
☒ Tufts Health Plan Commercial products – small group and individual plans
☒ Tufts Health Freedom Plan products – large group plans
☒ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:

All plans except Tufts Health Public Plans
PRECERT: 617.972.9409

Tufts Health Public Plans
MM: 888.415.9055

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION (FDA)-APPROVED INDICATIONS

Herceptin (trastuzumab) is a HER2/neu receptor antagonist indicated for the treatment of the following types of cancers:

Adjuvant Breast Cancer

- Adjuvant treatment of HER2 overexpressing node positive or node negative (ER/PR negative or with one high risk feature) breast cancer as part of a treatment regimen consisting of doxorubicin, cyclophosphamide, and either paclitaxel or docetaxel; as part of a treatment regimen with docetaxel and carboplatin; and as a single agent following mulit-modality anthracycline based therapy

Metastatic Breast Cancer

- In combination with paclitaxel for first-line treatment of HER2-overexpressing metastatic breast cancer
- As a single agent for treatment of HER2-overexpressing breast cancer in patients who have received one or more chemotherapy regimens for metastatic disease

Metastatic Gastric Cancer

- In combination with cisplatin and capecitabine or 5-fluorouracil, for the treatment of patients with HER2-overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma who have not received prior treatment for metastatic disease

Select patients for therapy based on an FDA-approved companion diagnostic for trastuzumab.

Trastuzumab is also available in combination with hyaluronidase indicated for treatment of breast cancer. Trastuzumab/hyaluronidase is administered via subcutaneous injection and has different dosage and administration instructions than intravenous trastuzumab products.

Trastuzumab is also available in combination with hyaluronidase and pertuzumab indicated for the treatment of breast cancer. Trastuzumab/pertuzumab/hyaluronidase is administered via subcutaneous injection and has different dosage and administration instructions than intravenous pertuzumab and trastuzumab products.

Available trastuzumab biosimilars include Herzuma (trastuzumab-pkrb), Kanjinti (trastuzumab-anns), Ogivri (trastuzumab-dkst), and Trazimera (trastuzumab-qyyp).

Phesgo (trastuzumab/pertuzumab/hyaluronidase-zzxf)
Phesgo (trastuzumab/pertuzumab/hyaluronidase-zzxf) is combination HER2/neu receptor antagonists and hyaluronidase indicated for the treatment of the following types of cancer:

Early Breast Cancer
- In combination with chemotherapy for the neoadjuvant treatment of adult patients with HER2-positive, locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive) as part of a complete treatment regimen for early breast cancer
- In combination with chemotherapy for the adjuvant treatment of adult patients with HER2-positive early breast cancer at high risk of recurrence

Metastatic Breast Cancer
- In combination with docetaxel for the treatment of adult patients with HER2-positive metastatic breast cancer who have not received prior anti-HER2 therapy or chemotherapy for metastatic disease

Select patients for therapy based on and FDA-approved companion diagnostic test.

COVERAGE GUIDELINES

Herceptin (trastuzumab) and Herceptin Hylecta (trastuzumab and hyaluroniadase-oysk)
The plan may authorize the coverage of Herceptin (trastuzumab) and Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) for Members, when all of the following criteria are met:
1. Documented previous failure of or clinical inappropriateness with a trastuzumab biosimilar

Phesgo (trastuzumab/pertuzumab/hyaluronidase-zzxf)
The plan may authorize the coverage of Phesgo (trastuzumab/pertuzumab/hyaluronidase-zzxf) for Members, when all of the following criteria are met:
1. Documented previous failure of or clinical inappropriateness with Perjeta (pertuzumab) in combination with a trastuzumab biosimilar

Off-label Use Coverage for Other Cancer Diagnoses
Coverage for other cancer diagnoses may be authorized provided effective treatment with such drug is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the Massachusetts commissioner of Insurance (commissioner) under the provisions of the "Sullivan Law": (M.G.L. c.175, s.47K).

The plan may authorize coverage for use for other cancer diagnoses provided effective treatment with such drug is recognized as a "Medically Accepted Indication" according to the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium as indicated by a Category 1 or 2A for quality of evidence and level of consensus.

Note: The plan requires prescribers to submit clinical documentation supporting the drug's effectiveness in treating the intended malignancy, including the applicable NCCN guideline(s).

In cases where the requested off-label use for the diagnosis is not recognized by the NCCN Drugs and Biologics Compendium, The plan will follow the Centers for Medicare and Medicaid Services (CMS) guidance, unless otherwise directed by the commissioner, and accept clinical documentation referenced in one of the other "Standard Reference Compendia" noted below or supported by clinical research that appears in a regular edition of a "Peer-Reviewed Medical Literature" noted below.

"Standard Reference Compendia"
1. American Hospital Formulary Service – Drug Information (AHFS-DI)
2. Thomson Micromedex DrugDex
3. Clinical Pharmacology (Gold Standard)
4. Wolters Kluwer Lexi-Drugs

"Peer Reviewed Medical Literature"
- American Journal of Medicine
- Annals of Internal Medicine
- Annals of Oncology
- Annals of Surgical Oncology
- Biology of Blood and Marrow Transplantation
- Gynecologic Oncology
- International Journal of Radiation, Oncology, Biology, and Physics
- The Journal of the American Medical Association
- Journal of Clinical Oncology

- Blood
- Bone Marrow Transplantation
- British Journal of Cancer
- British Journal of Hematology
- British Medical Journal
- Cancer
- Clinical Cancer Research
- Drugs
- European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology)
- Journal of the National Cancer Institute
- Journal of the National Comprehensive Cancer Network (NCCN)
- Journal of Urology
- Lancet
- Lancet Oncology
- Leukemia
- The New England Journal of Medicine
- Radiation Oncology

When the plan evaluates the evidence in published, peer-reviewed medical literature, consideration will be given to the following:

1. Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
2. Whether the administered chemotherapy regimen is adequately represented in the published evidence.
3. Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
4. Whether the study is appropriate to address the clinical question.
   a. whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question (e.g., in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover);
   b. 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; and,
   c. that case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.

LIMITATIONS

- Coverage of Herceptin (trastuzumab) or Herceptin Hylecta (trastuzumab and hyaluronidase-oysk) will be authorized for any FDA-approved indication that available biosimilars do not share.
- Documentation of any previous use of Herceptin (trastuzumab), Herceptin Hylecta (trastuzumab and hyaluronidase-oysk), or Phesgo (pertuzumab, trastuzumab, and hyaluronidase-zzxf) does not qualify as a clinically appropriate reason to not prescribe available biosimilars.
- Authorizations will be provided for 12 months.

CODES

The following HCPCS/CPT code(s) are:

Code	Description
J9355	Injection, trastuzumab, excludes biosimilar, 10 mg
J9356	Injection, trastuzumab, 10 mg and Hyaluronidase-oysk
J9316	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg

REFERENCES

1. Herceptin (trastuzumab) [prescribing information]. South San Francisco, CA: Genentech, Inc.; November 2018.
2. Herceptin Hylecta (trastuzumab and hyaluroniase-oysk) [prescribing information]. South San Francisco, CA: Genentech, Inc.; February 2019.
3. Kanjinti (trastuzumab-anns) [prescribing information]. Thousand Oaks, CA: Amgen Inc.; June 2019
4. Ogivri (trastuzumab-dkst) [prescribing information]. Steinhausen, Switzerland: Mylan GmbH; April 2019.
5. Phesgo (pertuzumab, trastuzumab, and hyaluronidase-zzxf) [prescribing information]. June 2020. South San Francisco, CA: Genentech, Inc.; June 2020.
6. Trazimera (trastuzumab-qyyp) [prescribing information]. New York, NY: Pfizer Inc.; March 2019.

APPROVAL HISTORY

January 14, 2020: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. April 14, 2020: Administrative update to add Trazimera (trastuzumab-qyyp) to the list of available trastuzumab biosimilars. Delayed the implementation date of the Medical Necessity Guideline to July 1, 2020.
2. July 14, 2020: Delayed the implementation date of the Medical Necessity Guideline to October 1, 2020.
3. September 15, 2020: Effective October 1, 2020, changed name of the Medical Necessity Guideline to "Trastuzumab Products (Herceptin®, Herceptin Hylecta™, Phesgo™). Added Phesgo to the Medical Necessity Guideline.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.