Pharmacy Medical Necessity Guidelines: Perjeta® (pertuzumab)

Effective: September 10, 2019

Prior Authorization Required √ Type of Review – Care Management
Not Covered Type of Review – Clinical Review √
Pharmacy (RX) or Medical (MED) Benefit MED 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
- CareLinkSM – 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 Direct – Health Connector: PRECERT: 617.972.9409
- Tufts Health Direct – Health Connector only: MM:888.415.9055

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

**OVERVIEW**

**FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS**
Perjeta (pertuzumab) is a HER2/neu receptor antagonist indicated:

- **Metastatic Breast Cancer (MBC)**
  - For use in combination with trastuzumab and docetaxel for the treatment of patients with HER2-positive MBC who have not received prior anti-HER2 therapy or chemotherapy for metastatic disease

- **Early Breast Cancer (EBC)**
  - For use in combination with trastuzumab and chemotherapy for the neoadjuvant treatment of 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
  - For use in combination with trastuzumab and chemotherapy for the adjuvant treatment of patients with HER2-positive early breast cancer at high risk of recurrence

**COVERAGE GUIDELINES**
The plan may authorize coverage of Perjeta (pertuzumab) for Members when all of the following criteria are met:

**Metastatic Breast Cancer (MBC)**
1. Documented diagnosis of HER2-positive metastatic breast cancer
   AND
2. Documentation the Member has not received prior anti-HER2 therapy or chemotherapy for metastatic disease
   AND
3. The prescribing physician is an oncologist

**Early Breast Cancer (EBC)**
1. Documentation of one of the following:
   a. Diagnosis of HER2-positive, locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive)
   b. Use as adjuvant treatment for a diagnosis of HER2-positive early breast cancer at high risk of recurrence
   AND
2. The prescribing physician is an oncologist
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
- 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)
- Gynecologic Oncology
- International Journal of Radiation, Oncology, Biology and Physics
- The Journal of the American Medical Association
- Journal of 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**

- The plan will not authorize the use of Perjeta (pertuzumab) for conditions other than those listed above without appropriate documentation.
- Coverage of Perjeta (pertuzumab) for early breast cancer is limited to six cycles.

**CODES**

The following HCPCS/CPT code(s) are:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>J9306</td>
<td>Injection, pertuzumab, 1 mg</td>
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**REFERENCES**


**APPROVAL HISTORY**

October 9, 2012: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
1. September 10, 2013: No changes.
4. October 7, 2014: No changes.
5. September 16, 2015: No changes.
7. August 9, 2016: No changes.
9. August 8, 2017: No changes
10. August 7, 2018: Updated coverage criteria for updated and new indications in the treatment of early breast cancer. Based on updated package labeling, changed the following coverage Limitation “Coverage of Perjeta (pertuzumab) for the neoadjuvant treatment of patients with HER2-positive, locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive) is limited to six cycles” to “Coverage of Perjeta (pertuzumab) for early breast cancer is limited to six cycles.”
11. September 10, 2019: No changes

**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.