Policy Title:	Herceptin (trastuzumab) (Intravenous)		
		Department:	PHA
Effective Date:	10/15/2019		
Review Date:	09/18/19, 12/18/19, 1/29/20, 3/18/20		
Revision Date:	09/18/19, 1/29/20, 3/18/20		

Purpose: To support safe, effective and appropriate use of Herceptin (trastuzumab).

Scope: Medicaid, Exchange, Medicare-Medicaid Plan (MMP)

Policy Statement:

Herceptin (trastuzumab) is covered under the Medical Benefit when used within the following guidelines. Use outside of these guidelines may result in non-payment unless approved under an exception process.

Procedure:

Coverage of Herceptin (trastuzumab) will be reviewed prospectively via the prior authorization process based on criteria below.

Initial Criteria:

- Baseline left ventricular ejection fraction (LVEF) within normal limits; AND
- Patient is 18 years or older; AND
- Patient's cancer is human epidermal growth factor receptor 2 (HER2)-positive and meets the following criteria:
    - Immunohistochemistry (IHC) assay 3+; OR
    - In situ hybridization (ISH) assay average HER2 copy number ≥ 6.0 signals/cell; OR
    - Dual-probe in situ hybridization (ISH) assay HER2/CEP17 ratio ≥ 2.0; AND
- For patients requesting Herceptin, Ogivri or Herzuma as a new start to therapy, the patient must have documentation of inadequate outcome/failure or intolerable side effects to one of the preferred agents Kanjinti or Trazimera; OR
- Patients that are currently on treatment with Herceptin (trastuzumab), Ogivri or Herzuma can remain on treatment OR MMP members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements

Breast cancer

- Used as adjuvant therapy in combination with a taxane-based regimen (e.g., docetaxel, paclitaxel, etc.) OR as a single agent following anthracycline-based therapy ; OR
- Used as neoadjuvant therapy for breast preservation in combination with a taxane-based regimen (e.g., docetaxel, paclitaxel, etc.); OR

- Used for recurrent or metastatic disease; AND
    - Used as a single agent in patients who have received one or more prior treatments for metastatic disease ; OR
    - Used in first-line therapy in combination with paclitaxel; OR
    - Used in combination with endocrine therapy in patients with hormone-receptor positive or asymptomatic visceral disease; AND
        - Patient is post-menopausal; OR
        - Patient is pre-menopausal treated with ovarian ablation/suppression if prior endocrine therapy within 1 year or patient had no prior endocrine therapy within 1 year; OR
        - Patient is a male receiving concomitant suppression of testicular steroidogenesis; OR
    - Used in combination with cytotoxic chemotherapy OR lapatinib OR pertuzumab and a taxane as first-line therapy OR pertuzumab as second-line therapy in patients who were previously treated with trastuzumab without pertuzumab; AND
        - Disease is hormone receptor-negative; OR
        - Disease is hormone receptor-positive and refractory to endocrine therapy; OR
        - Patient has symptomatic visceral disease or visceral crisis

Gastric, Esophageal and Esophagogastric Junction Cancers

- Used in combination with cisplatin and 5-FU or capecitabine for first-line therapy; AND
- Patient has metastatic adenocarcinoma

Continuation of Therapy coverage:

- Patient continues to meet initial criteria; AND
- Tumor response with stabilization of disease or decrease in size of tumor or tumor spread; AND
- Patient is tolerating treatment with absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: cardiotoxicity (e.g., left ventricular dysfunction, cardiomyopathy, etc.), pulmonary toxicity (i.e., pneumonitis), neutropenia, infusion-related reactions, etc.; AND
- Left ventricular ejection fraction (LVEF) has not had an absolute decrease of more than 15% from baseline and is within normal limits; AND
- Use for neoadjuvant and adjuvant breast cancer treatment is limited to a total of 52 weeks of therapy

Dosage/Administration:

Indication	Dose (1 billable unit = 10 mg)	Maximum units
Breast Cancer, Gastric, Esophageal and Esophagogastric Junction Cancers	Loading dose: 8 mg/kg x 1 for every 21 day dosing schedule Maintenance dose: 6 mg/kg every 21 days **OR** Loading dose: 4 mg/kg x 1 for weekly dosing schedule Maintenance dose: 2 mg/kg every 7 days	7-day dosing: Load: 45 units Maintenance: 30 units 21-day dosing schedule: Load: 90 units Maintenance: 75 units

Coverage durations:

- Initial coverage: 6 months
- Renewal coverage: 6 months

*** Requests will also be reviewed to National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) if applicable. ***

Investigational use: All therapies are considered investigational when used at a dose or for a condition other than those that are recognized as medically accepted indications as defined in any one of the following standard reference compendia: American Hospital Formulary Service Drug information (AHFS-DI), Thomson Micromedex DrugDex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs, or Peer-reviewed published medical literature indicating that sufficient evidence exists to support use. Neighborhood does not provide coverage for drugs when used for investigational purposes.

Applicable Codes:
Below is a list of billing codes applicable for covered treatment options. The below tables are provided for reference purposes and may not be all inclusive. Requests received with codes from tables below do not guarantee coverage. Requests must meet all criteria provided in the procedure section.

The following HCPCS/CPT code is:

HCPCS/CPT Code	Description
J9355	Injection, trastuzumab, 10 mg;

References:

1. Herceptin [package insert]. South San Francisco, CA; Genentech, Inc; May 2019.
2. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) trastuzumab. National Comprehensive Cancer Network, 2019. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc." To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed January 2019.
3. Zagouri F, Sergentanis TN, Bartsch R, et al. Intrathecal administration of trastuzumab for the treatment of meningeal carcinomatosis in HER2-positive metastatic breast cancer: a systematic review and pooled analysis. Breast Cancer Res Treat 2013; 139:13
4. First Coast Service Options, Inc. Local Coverage Determination (LCD): Trastuzumab (Herceptin®) (L34026). Centers for Medicare & Medicaid Services, Inc. Updated on 7/7/2017 with effective date 7/14/2017. Accessed January 2019.