trastuzumab

Medicare Part B Drug Policy

- Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category).
- Medicare Benefit Policy Manual - Pub. 100-02, Chapter 15, Section 50, describes national policy regarding Medicare guidelines for coverage of drugs and biologicals.
- Blue Shield of California (BSC) follows Medicare statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and policy articles for determining coverage for Part B drug requests when applicable.
- BSC Medicare Part B Drug Policies will be used when coverage criteria are not fully established or there is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs.

Drug Details

USP Category: ANTINEOPLASTICS

Mechanism of Action: Mechanism of action: Recombinant DNA-derived humanized anti-HER2 monoclonal antibody which is a mediator of antibody-dependent cellular cytotoxicity (ADCC).

HCPCS:

J9355:Injection, trastuzumab, excludes biosimilar, 10 mg
Q5112:Injection, trastuzumab-dttb, biosimilar, (ontruzant), 10 mg
Q5113:Injection, trastuzumab-pkrb, biosimilar, (herzuma), 10 mg
Q5114:Injection, trastuzumab-dkst, biosimilar, (ogivri), 10 mg
Q5116:Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg
Q5117:Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg

How Supplied:

Herceptin®

- 150 mg single-dose vial (lyophilized powder for reconstitution)

Herzuma®

- 150 mg single-dose vial (lyophilized powder for reconstitution)
- 420 mg multiple-dose vial (lyophilized powder for reconstitution)

Trazimera™

- 150 mg single-dose vial (lyophilized powder for reconstitution)
- 420 mg multiple-dose vial (lyophilized powder for reconstitution)

Kanjinti™

- 150 mg single-dose vial (lyophilized powder for reconstitution)
- 420 mg multiple-dose vial (lyophilized powder for reconstitution)

Ogivri™

- 150 mg single-dose vial (lyophilized powder for reconstitution)
- 420 mg multiple-dose vial (lyophilized powder for reconstitution)

Ontruzant®

- 150 mg single-dose vial (lyophilized powder for reconstitution)
- 420 mg multiple-dose vial (lyophilized powder for reconstitution)

Condition(s) listed in policy (see coverage criteria for details)

- Appendiceal or Colorectal Cancer
- Biliary tract cancers (Hepatobiliary cancers) - Cholangiocarcinoma and gallbladder cancer
- Breast cancer
- Endometrial Carcinoma
- Esophageal Cancer, Esophagogastric Junction Cancer, or Gastric Cancer
- Head and Neck Cancer, Salivary Gland Tumors

Any request for a condition not listed in policy must meet the definition of a medically accepted indication. Section 1861(t)(2)(B) of the Act defines "medically-accepted indication," as any use of a prescription drug or biological product which is approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included (or approved for inclusion) in one or more of the CMS approved compendia.

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

For members enrolled in our Blue Shield Select (PPO) and Blue Shield Medicare (PPO) plans:
Herceptin, Ogivri, Herzuma, and Ontruzant requires step therapy. Step therapy requires you to try other drugs first before another drug can be covered. The BSC preferred step drugs are Kanjinti and Trazimera. Both of these drugs will need to be tried for members newly initiating Herceptin, Ogivri, Herzuma, or Ontruzant therapy.

Coverage Criteria
The following condition(s) require Prior Authorization/Preservice:

Appendiceal or Colorectal Cancer
Meets medical necessity if all the following are met:
1. Disease is unresectable, advanced, or metastatic
2. Being used in combination with pertuzumab, lapatinib, or tucatinib
3. HER2-positivity/amplified
4. RAS wild-type
5. BRAF wild-type
6. Patient has not received prior treatment with a HER2 inhibitor
7. **For PPO request for Herceptin, Herzuma, Ogivri or Ontruzant:** Intolerable side effect with the preferred trastuzumab products, Kanjinti and Trazimera, that is not expected with the requested drug, or contraindication to Kanjinti and Trazimera.

Covered Doses:
Up to 8 mg/kg IV for the first dose, followed by up to 6 mg/kg IV every 3 weeks, OR
Up to 4 mg/kg IV for the first dose, followed by up to 2 mg/kg IV every week

Coverage Period:
Yearly

ICD-10:
C17.0-C17.2, C17.8, C17.9, C18.0-C18.9, C19, C20, C21.8, C78.00-C78.02, C78.6, C78.7, Z85.038, Z85.068

Biliary tract cancers (Hepatobiliary cancers) - Cholangiocarcinoma and gallbladder cancer
Meets medical necessity if all the following are met:

1. Being used for unresectable or metastatic disease
2. Being used for subsequent therapy
3. HER2-positivity
4. Given in combination with pertuzumab
5. **For PPO request for Herceptin, Herzuma, Ogivri or Ontruzant:** Intolerable side effect with the preferred trastuzumab products, Kanjinti and Trazimera, that is not expected with the requested drug, or contraindication to Kanjinti and Trazimera.

Covered Doses:
Up to 8 mg/kg for the first dose, followed by up to 6 mg/kg every 3 weeks

Coverage Period:
Yearly

ICD-10:
C22.1, C23, C24.0, C24.8, C24.9

Breast cancer
Meets medical necessity if all the following are met:

1. HER2-positivity
2. For PPO request for Herceptin, Herzuma, Ogivri or Ontruzant: Intolerable side effect with the preferred trastuzumab products, Kanjinti and Trazimera, that is not expected with the requested drug, or contraindication to Kanjinti and Trazimera.

Covered Doses:
Neoadjuvant/Adjuvant:
Up to 4 mg/kg IV for the first dose, followed by 2 mg/kg IV weekly for 12 weeks (with paclitaxel or docetaxel) or 18 weeks (with docetaxel and carboplatin). One week after the last weekly dose of trastuzumab, can allow up to 6 mg/kg IV every three weeks to complete a total of 52 weeks of therapy.
OR
Up to 8 mg/kg IV for the first dose, followed by 6 mg/kg IV every three weeks for 52 weeks.

Recurrent or Metastatic:
Up to 4 mg/kg IV for the first dose, then up to 2 mg/kg IV every week
OR
Up to 8 mg/kg IV for the first dose, then up to 6 mg/kg IV every three weeks

For Leptomeningeal metastases: Up to 150 mg via intrathecal or intraventricular administration given once weekly

Coverage Period:
Neoadjuvant/ Adjuvant therapy:
Cover maximum of 1 year (Number of doses is dependent on regimen)
No reauthorization.

Recurrent or Metastatic:
Yearly

ICD-10:
C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, Z85.3

Endometrial Carcinoma
Meets medical necessity if all the following are met:
1. Histology is carcinosarcoma or uterine serous carcinoma
2. Disease is advanced (stage III or IV) or recurrent
3. HER2-positivity
4. Given in combination with carboplatin and paclitaxel
5. For PPO request for Herceptin, Herzuma, Ogivri or Ontruzant: Intolerable side effect with the preferred trastuzumab products, Kanjinti and Trazimera, that is not expected with the requested drug, or contraindication to Kanjinti and Trazimera

Covered Doses:
Up to 8 mg/kg IV for the first dose, then up to 6 mg/kg IV every three weeks

Coverage Period:
Yearly

ICD-10:
C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, Z85.42

Esophageal Cancer, Esophagogastric Junction Cancer, or Gastric Cancer
Meets medical necessity if all the following are met:
1. ONE of the following:
   a. Being used as induction systemic therapy for relieving dysphagia in esophageal cancer or ESG cancer patients planned for esophagectomy, or
   b. Being used for early-stage gastric cancer, or
   c. Disease is unresectable locoregional/locally advanced, recurrent or metastatic, and being used as first line therapy
2. HER2-positivity
3. Given in combination with systemic chemotherapy

4. For PPO request for Herceptin, Herzuma, Ogivri or Ontruzant: Intolerable side effect with the preferred trastuzumab products, Kanjinti and Trazimera, that is not expected with the requested drug, or contraindication to Kanjinti and Trazimera.

Covered Doses:
Up to 8 mg/kg for the first dose, followed by up to 6 mg/kg every 3 weeks
OR
Up to 6 mg/kg for the first dose, followed by up to 4 mg/kg every 2 weeks

Coverage Period:
Yearly

ICD-10:
C15.3-C15.5, C15.8, C15.9, C16.0, C16.0-C16.6, C16.8, C16.9, D37.1, D37.8, D37.9, Z85.00, Z85.028

Head and Neck Cancer, Salivary Gland Tumors
Meets medical necessity if all the following are met:
1. Diagnosis of salivary gland tumor
2. Recurrent, unresectable, or metastatic disease
3. HER2-positivity
4. Being used as single agent or in combination with docetaxel or pertuzumab
5. For PPO request for Herceptin, Herzuma, Ogivri or Ontruzant: Intolerable side effect with the preferred trastuzumab products, Kanjinti and Trazimera, that is not expected with the requested drug, or contraindication to Kanjinti and Trazimera.

Covered Doses:
Up to 8 mg/kg for the first dose, followed by up to 6 mg/kg every 3 weeks

Coverage Period:
Yearly

ICD-10:
C06.9, C07, C08.0, C08.9

Additional Information

Summary of Evidence
The contents of this policy were created after examining the following resources:
1. The prescribing information for Herceptin, Kanjinti, Ogivri, Ontruzant, Herzuma, Trazimera.
2. CMS approved compendium in accordance with the accepted compendia ratings listed:
   a. Micromedex DrugDex - Class I, Class IIa, of Class IIb
   b. American Hospital Formulary Service-Drug Information (AHFS-DI) - supportive narrative text
   c. National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium - Category 1 or 2A
   d. Lexi-Drugs – "Use: Off-Label" and rated as "Evidence Level A" (cancer indications only)

e. Clinical Pharmacology - supportive narrative text (cancer indications only)
3. Noridian Healthcare Solutions Medicare: Drugs, Biologics and Injections
4. NCCN Guideline: Biliary tract cancers
5. NCCN Guideline: Breast cancer
6. NCCN Guideline: Central nervous system cancers
7. NCCN Guideline: Colon cancer
8. NCCN Guideline: Esophageal and esophagogastric junction cancers
9. NCCN Guideline: Gastric cancer
10. NCCN Guideline: Head and neck cancers
11. NCCN Guideline: Rectal cancer
12. NCCN Guideline: Uterine neoplasms

After reviewing the information in the above resources, the FDA-approved indications listed in the prescribing information for Herceptin, Kanjinti, Ogivri, Ontruzant, Herzuma, Trazimera are covered in addition to the following:

- Breast cancer
- Colorectal cancer
- Endometrial cancer
- Esophageal cancer, esophagogastric junction cancer, or gastric cancer
- Head and neck cancer, salivary gland tumors
- Hepatobiliary cancers (cholangiocarcinoma and gallbladder cancer)

Explanation of Rationale:

- Support for FDA-approved indications can be found in the manufacturer's prescribing information.
- Support for using biosimilars as step requirement is found in Noridian Health Care Solutions and supported by the FDA. Noridian will accept a biosimilar drug on the same criteria as the drug to which it is a biosimilar unless an article is published to the contrary. Per the FDA, a biosimilar is highly similar to and has no clinically meaningful difference from an existing FDA approved biologic reference drug.
- Support for using biosimilars in oncology can be found in The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) via the footnote on the reference product (an FDA-approved biosimilar is an appropriate substitute) and in the NCCN Drugs & Biologics Compendium® by the notation that a biosimilar agent may be an appropriate substitute for the reference product.
- Support for the listed indications is found in the National Comprehensive Cancer Network's (NCCN) Drugs and Biologics Compendium.
  - Breast cancer
  - Colorectal cancer
  - Endometrial carcinoma
  - Esophageal cancer, esophagogastric junction cancer, or gastric cancer
- Support for using Herceptin for head and neck cancer is found in the National Comprehensive Cancer Network's (NCCN) guideline for head and neck cancers. The NCCN Guideline for head and neck cancers supports the use of Herceptin in certain circumstances as systemic therapy as a single agent, in combination with docetaxel, or in combination with pertuzumab for human epidermal growth factor receptor 2 (HER2)-positive recurrent disease with

- Distant metastases in patients with a performance status (PS) of 0-3
- Unresectable locoregional recurrence or second primary with prior radiation therapy

- Support for using Herceptin for hepatobiliary cancers is found in the National Comprehensive Cancer Network's (NCCN) guideline for biliary tract cancers supports the use of Herceptin for subsequent in treatment in combination with either pertuzumab or tucatinib for progression on or after systemic treatment for unresectable or resected gross residual (R2) disease, or metastatic disease that is HER2-positive (useful in certain circumstances).

References

1. CMS Benefit Policy Manual. Chapter 15; § 50 Drugs and Biologicals
2. Medicare Coverage Database. Available at https://www.cms.gov/Medicare-Coverage-Database/search.aspx
3. Social Security Act (Title XVIII) Standard References, Sections: 1862(a)(1)(A) Medically Reasonable & Necessary; 1862(a)(1)(D) Investigational or Experimental; 1833(e) Incomplete Claim; 1861(t) (1) Drugs and Biologicals
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6. Herceptin® (trastuzumab) [Prescribing information]. South San Francisco, CA: Genentech, Inc.; 2/2021.
7. Herzuma (trastuzumab-pkrb) [Prescribing Information]. North Wales, PA: Teva Pharmaceuticals; 04/2021.
8. Kanjinti (trastuzumab-anns) [Prescribing Information]. Thousand Oaks, CA: Amgen; 10/2019.
9. Ogivri (trastuzumab-dkst). [Prescribing Information]. Morgantown, WV: Mylan Pharmaceuticals; 5/2023.
10. Ontruzant (trastuzumab-dttb). [Prescribing Information]. Jersey City, NJ: Organon; 6/2021.
11. National Comprehensive Cancer Network. Biliary Tract Cancers (Version 2.2024). Available at http://www.nccn.org.
12. National Comprehensive Cancer Network. Breast Cancer (Version 2.2024). Available at http://www.nccn.org.
13. National Comprehensive Cancer Network. Central Nervous System Cancers (Version 1.2023). Available at http://www.nccn.org.
14. National Comprehensive Cancer Network. Colon Cancer (Version 3.2024). Available at http://www.nccn.org.
15. National Comprehensive Cancer Network. Esophageal and Esophagogastric Junction Cancers (Version 3.2024). Available at http://www.nccn.org.
16. National Comprehensive Cancer Network. Gastric Cancer (Version 2.2024). Available at http://www.nccn.org.
17. National Comprehensive Cancer Network. Head and Neck Cancers (Version 4.2024). Available at http://www.nccn.org.
18. National Comprehensive Cancer Network. Rectal Cancer (Version 2.2024). Available at http://www.nccn.org.
19. National Comprehensive Cancer Network. Uterine Neoplasms (Version 2.2024). Available at http://www.nccn.org.
20. Trazimera (trastuzumab-qyyp) [Prescribing Information]. New York, NY: Pfizer; 11/2020.

Review History

Date of Last Annual Review: 3Q2024

Changes from previous policy version:

- New Part B policy

Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee

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