

# POLICY Document for Herceptin (trastuzumab)

The overall objective of this policy is to support the appropriate and cost effective use of the medication. This document provides specific information to each section of the overall policy.

## Section 1: Clinical Criteria

- Policy information specific to the clinical appropriateness for the medication

## Section 2: Oncology Clinical Policy

- Policy information specific to regimen review per NCCN Guidelines.

## Section 1: Clinical Criteria

### SPECIALTY GUIDELINE MANAGEMENT

#### HERCEPTIN (trastuzumab)

#### POLICY

##### I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

##### A. FDA-Approved Indications

###### 1. Adjuvant breast cancer

Treatment of human epidermal growth factor receptor 2 (HER2)-overexpressing node positive or node negative (estrogen receptor (ER)/progesterone receptor (PR) negative or with one high risk feature) breast cancer:

- a. As part of a treatment regimen consisting of doxorubicin, cyclophosphamide, and either paclitaxel or docetaxel
- b. As part of a treatment regimen with docetaxel and carboplatin
- c. As a single agent following multi-modality anthracycline based therapy

###### 2. Metastatic breast cancer

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

###### 3. 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

##### B. Compendial Uses

###### 1. HER2-positive breast cancer

- a. Neoadjuvant therapy
- b. Treatment of recurrent or stage IV (M1) disease

###### 2. Intra-cerebrospinal fluid (CSF) treatment for leptomeningeal metastases from breast cancer

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3. HER2-positive esophageal and esophagogastric junction cancer
4. HER2- positive advanced and recurrent uterine serous carcinoma

All other indications are considered experimental/investigational and are not a covered benefit.

## II. CRITERIA FOR INITIAL APPROVAL

### A. Breast Cancer

1. Authorization of 6 months may be granted for neoadjuvant treatment of HER2-positive breast cancer.
2. Authorization of up to 12 months total may be granted for adjuvant treatment of HER2-positive breast cancer.
3. Authorization of 12 months may be granted for treatment of HER2-positive recurrent or metastatic breast cancer.
4. Authorization of 12 months may be granted for intra-CSF treatment for leptomeningeal metastases from breast cancer.

### B. Esophageal, Gastric, or Gastroesophageal Junction Cancer

Authorization of 12 months may be granted for treatment of HER2-positive esophageal, gastric, or gastroesophageal junction cancer.

### C. Uterine Serous Carcinoma

Authorization of 12 months may be granted for treatment of HER2-positive advanced and recurrent uterine serous carcinoma.

## III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

# Section 2: Oncology Clinical Policy

## Oncology Clinical Policy

### Program Description

The National Comprehensive Care Network® (NCCN®) is an alliance of leading cancer centers devoted to patient care, research and education dedicated to improving the quality, effectiveness and efficiency of cancer care so patients can live better lives.<sup>1</sup> It is comprised of oncology experts who convene regularly to establish the best treatments for patients. NCCN develops various resources for use by stakeholders in the health care delivery system. These resources include, but are not limited to, the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®), the NCCN Drugs & Biologics Compendium (NCCN Compendium®) and the NCCN Chemotherapy Order Templates (NCCN Templates®).

NCCN templates are based on NCCN Clinical Practice Guidelines and NCCN Compendium. The NCCN Compendium lists the appropriate drugs and biologics for specific cancers using U.S. Food and Drug Administration (FDA)-approved disease indications and specific NCCN panel recommendations. Each recommendation is supported by a level of evidence category.

## NCCN Categories of Evidence and Consensus<sup>2</sup>

- Category 1: Based on high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
- Category 2A: Based on lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
- Category 2B: Based on lower-level evidence, there is NCCN consensus that the intervention is appropriate.
- Category 3: Based any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

## Policy for Regimen Prior Authorization

A regimen prior authorization allows submission of a single prior authorization request for all oncology drugs or biologics within an NCCN template that require prior authorization.

This policy provides coverage of a regimen review when *all* of the following criteria are met:

- a. Regimen prior authorization reviews, based on NCCN templates, are initiated through the provider portal: <https://provider.carefirst.com/providers/home.page>
  - b. If the prior authorization request is submitted via phone or fax, each drug or biologic will need to be submitted and reviewed as a separate prior authorization request for review with drug-specific criteria.
2. The prior authorization review is requested for an oncology drug or biologic that requires prior authorization on the medical benefit.
  3. The indication is for a cancer that is eligible for regimen review. Currently, the cancer types in scope for regimen review include breast, lung, colon and rectal cancer.
  4. The member is eligible for regimen review.

In addition, the following criteria must be met for approval:

1. The requested regimen for the drug(s) or biologic(s) and indication is consistent with an NCCN recommendation with a level of evidence category of 1 or 2A.
2. The NCCN template must be accepted by the provider without modification.

Authorizations may be granted for 12 months.

Further review may be indicated where the above criteria are not met.

## Continuation of Therapy

To submit a request for continuation of therapy, a new regimen prior authorization review must be requested. Upon template selection, the template must be modified to include the appropriate therapies being used for maintenance treatment. The regimen request will be submitted for further review.

## Dosage and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia and/or evidence-based practice guidelines.

## REFERENCES:

### SECTION 1

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### SECTION 2

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2. National Comprehensive Cancer Network. NCCN Categories of Evidence and Consensus website. [https://www.nccn.org/professionals/physician\\_gls/categories\\_of\\_consensus.aspx](https://www.nccn.org/professionals/physician_gls/categories_of_consensus.aspx), accessed September 16, 2019.
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