Perjeta (pertuzumab)

Line(s) of Business: HMO; PPO; QUEST Integration Medicare Advantage

Original Effective Date: 10/01/2015

Current Effective Date: 01/01/2018

POLICY

A. 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.

FDA-Approved Indications

- Metastatic breast cancer
  - In combination with trastuzumab and docetaxel for the treatment of patients with human epidermal growth factor receptor 2 (HER2)-positive metastatic breast cancer who have not received prior anti-HER2 therapy or chemotherapy for metastatic disease

- Neoadjuvant treatment of breast cancer
  - In combination with trastuzumab and docetaxel 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.

Limitations of Use:

- The safety of Perjeta as part of a doxorubicin-containing regimen has not been established.
- The safety of Perjeta administered for greater than six cycles for early breast cancer has not been established.

Compendial Uses

- Preoperative systemic therapy for patients with HER2-positive stage IIA (T2, N0, M0), stage IIB (T2, N1, M0 or T3, N0, M0) or stage IIIA (T3, N1, M0) tumors who desire breast preservation and fulfill criteria for breast-conserving surgery except for tumor size or for locally advanced disease (stage IIIA, IIB, or IIC)
  - In combination with trastuzumab and paclitaxel (preferred regimen) or trastuzumab and docetaxel following AC (doxorubicin and cyclophosphamide) regimen
  - In combination with TCH (docetaxel, carboplatin, and trastuzumab) regimen (preferred regimen)
Perjeta

- In combination with trastuzumab and paclitaxel or trastuzumab and docetaxel prior to or following FEC (fluorouracil, epirubicin, and cyclophosphamide) regimen

- Adjuvant systemic therapy for patients with ≥T2 or ≥N1 HER2-positive early stage or locally advanced breast cancer if a pertuzumab-containing regimen was not used as neoadjuvant therapy
  - In combination with trastuzumab and paclitaxel (preferred regimen) or trastuzumab and docetaxel following AC (doxorubicin and cyclophosphamide) regimen
  - In combination with TCH (docetaxel, carboplatin, and trastuzumab) regimen
  - In combination with trastuzumab and paclitaxel or trastuzumab and docetaxel prior to or following FEC (fluorouracil, epirubicin, and cyclophosphamide) regimen

- Recurrent or metastatic HER2-positive breast cancer that is either hormone receptor (HR)-negative or HR-positive and endocrine therapy refractory or with symptomatic visceral disease/visceral crisis:
  - In combination with trastuzumab with docetaxel or paclitaxel as preferred first-line therapy
  - In combination with trastuzumab with or without cytotoxic therapy (e.g., vinorelbine or taxane) for one line of therapy beyond first-line therapy in patients previously treated with chemotherapy and trastuzumab in the absence of pertuzumab

B. REQUIRED DOCUMENTATION

The following information is necessary to initiate the prior authorization review:
- For initial therapy
  - Current oncology notes, clinical notes (including previous treatment history), treatment plans, and any pertinent pathology reports and/or imaging studies
  - HER2 test result
  - HR test result (if applicable)
  - Cancer staging (if applicable)
- For continuation therapy
  - Documentation demonstrating lack of disease progression on therapy

C. PRESCRIBER RESTRICTION

- Perjeta must be prescribed by an oncologist.

D. INITIAL CRITERIA FOR APPROVAL

1. Breast cancer
   a. Member must have HER2-positive breast cancer.
   b. Authorization of 3 months may be granted to members who are prescribed Perjeta as neoadjuvant therapy for the treatment of breast cancer when ALL of the following criteria are met:
      i. Member has locally advanced, inflammatory, or early-stage breast cancer (either greater than 2 cm in diameter or node positive) AND
      ii. Perjeta must be used in combination with ONE of the following regimens:
         1) Trastuzumab and docetaxel
         2) Trastuzumab and paclitaxel
         3) TCH (docetaxel, carboplatin, and trastuzumab) regimen
c. Authorization of 3 months may be granted to members who are prescribed Perjeta as 
adjuvant therapy for the treatment of breast cancer when ALL of the following criteria are 
met:
   i. A Perjeta-containing regimen was not used as neoadjuvant therapy AND
   ii. Disease must be ≥T2 or ≥N1 early stage or locally advanced breast cancer AND
   iii. Perjeta must be used in combination with ONE of the following regimens:
      1) Trastuzumab and docetaxel
      2) Trastuzumab and paclitaxel
      3) TCH (docetaxel, carboplatin, and trastuzumab) regimen

d. Authorization of 3 months may be granted for the treatment of recurrent or metastatic 
breast cancer when ALL of the following criteria are met:
   i. Disease is classified as one of the following:
      1) HR-negative disease
      2) HR-positive disease refractory to endocrine therapy
      3) Symptomatic visceral disease
      4) Disease with visceral crisis
   ii. Perjeta must be used in combination with ONE of the following regimens:
      1) For members who have NOT experienced prior progression on trastuzumab-
         based therapy, Perjeta will be used with trastuzumab and a taxane (e.g.,
         paclitaxel, docetaxel, or albumin-bound paclitaxel)
      2) For members who have experienced prior progression on trastuzumab-based 
         therapy AND who have NOT been previously treated with a regimen 
         containing Perjeta, Perjeta will be used with trastuzumab with or without 
         cytotoxic therapy (e.g., vinorelbine or taxane).

E. CONTINUATION OF THERAPY
   1. No previous authorization/precertification:
      All members (including new members and members currently receiving treatment without prior 
      authorization) must meet criteria for initial approval in section D.
   2. Reauthorization:
      Authorization of 3 months may be granted to members who are prescribed Perjeta for 
      continuation of therapy if Perjeta was previously authorized by HMSA/CVS and there is evidence 
      of benefit from therapy.

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

G. ADMINISTRATIVE GUIDELINES
   Prior authorization is required. Please refer to the HMSA medical policy web site for the fax form.

H. IMPORTANT REMINDER
   The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not
   intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended 
   to discourage or prohibit providing other medical advice or treatment deemed appropriate by the 
   treating physician.
Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA/CVS’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

I. REFERENCES

Document History

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