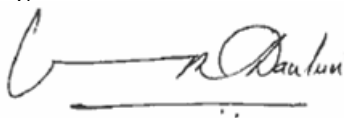


Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	Submission Date: 02/01/2023
Policy Number: PA.CP.PHAR.456	Effective Date: 10/2020 Revision Date: 01/2023
Policy Name: Fam-trastuzumab Deruxtecan-nxki (Enhertu)	
<p>Type of Submission – <u>Check all that apply</u>:</p> <p> <input type="checkbox"/> New Policy <input checked="" type="checkbox"/> Revised Policy* <input type="checkbox"/> Annual Review - No Revisions <input type="checkbox"/> Statewide PDL - <i>Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.</i> </p>	
<p>*All revisions to the policy <u>must</u> be highlighted using track changes throughout the document.</p> <p>Please provide any changes or clarifying information for the policy below:</p> <p>1Q 2023 annual review: added criteria for new FDA-approved indications for NSCLC and HER2-low breast cancer, references reviewed and updated. added off-label use for advanced or metastatic colon and rectal cancers per NCCN; for NSCLC removed the criterion to require treatment of non-HER2 mutations first, to align with NCCN recommendations; added recurrent gastric or GEJ cancer as a covered indication per NCCN; RT4: added language to the FDA Approved Indications section re: using an FDA-approved test to identify HER2-low breast cancer; references reviewed and updated.</p>	
Name of Authorized Individual (Please type or print): Venkateswara R. Davuluri, MD	Signature of Authorized Individual: 

Clinical Policy: Fam-trastuzumab Deruxtecan-nxki (Enhertu)

Reference Number: PA.CP.PHAR.456

Effective Date: 10/2020

Last Review Date: 01/2023

[Coding Implications](#)[Revision Log](#)**Description**

Fam-trastuzumab deruxtecan-nxki (Enhertu[®]) is a human epidermal growth factor receptor 2 (HER2)-directed antibody and topoisomerase inhibitor conjugate.

FDA Approved Indication(s)

Enhertu is indicated for the treatment of adult patients with:

- Unresectable or metastatic HER2-positive breast cancer who have received a prior anti-HER2 based regimen either:
 - In the metastatic setting, or
 - In the neoadjuvant or adjuvant setting and have developed disease recurrence during or within six months of completing therapy.
- Unresectable or metastatic HER2-low (IHC 1+ or IHC 2+/ISH-) breast cancer, as determined by an FDA-approved test, who have received a prior chemotherapy in the metastatic setting or developed disease recurrence during or within 6 months of completing adjuvant chemotherapy.
- Unresectable or metastatic non-small cell lung cancer (NSCLC) whose tumors have activating HER2 (ERBB2) mutations, as detected by an FDA-approved test, and who have received a prior systemic therapy*.
- Locally advanced or metastatic HER2-positive gastric or gastroesophageal junction (GEJ) adenocarcinoma who have received a prior trastuzumab-based regimen.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of PA Health & Wellness[®] that Enhertu is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Breast Cancer** (must meet all):

1. Diagnosis of recurrent, unresectable, or metastatic breast cancer that is one of the following (a or b):
 - a. HER2-positive;
 - b. HER2-low (IHC 1+ or IHC 2+/ISH-);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. One of the following (a or b):
 - a. For HER2-positive breast cancer, one of the following (i or ii):
 - i. Failure of one prior anti-HER2-based regimen (*see Appendix B*), unless contraindicated or clinically significant adverse effects are experienced;

- ii. Rapid disease progression within 6 months of neoadjuvant or adjuvant therapy (12 months for pertuzumab-containing regimens);
**Prior authorization may be required for anti-HER2-based regimens*
- b. For HER2-low (IHC 1+ or IHC2+/ISH-) breast cancer, one of the following (i or ii):
 - i. Failure of at least one prior line of chemotherapy (if hormone-receptor [HR]-positive, previous therapy should include an endocrine therapy, unless ineligible) (*see Appendix B for examples*);
 - ii. Disease recurrence during or within 6 months of completing adjuvant chemotherapy;
- 5. Request meets one of the following (a or b):
 - a. Dose does not exceed 5.4 mg/kg every 3 weeks;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

B. Gastric and Gastroesophageal Junction Cancer (must meet all):

- 1. Diagnosis of HER2-positive gastric or GEJ adenocarcinoma;
- 2. Prescribed by or in consultation with an oncologist;
- 3. Age \geq 18 years;
- 4. Disease is locally advanced, recurrent or metastatic;
- 5. Failure of trastuzumab-based regimen (*see Appendix B*);
- 6. Request meets one of the following (a or b):
 - a. Dose does not exceed 6.4 mg/kg every 3 weeks;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

C. Non-Small Cell Lung Cancer (must meet all):

- 1. Diagnosis of unresectable, advanced or metastatic NSCLC;
- 2. Disease has activating HER2 (ERBB2) mutations;
- 3. Prescribed by or in consultation with an oncologist;
- 4. Age \geq 18 years;
- 5. Failure of one prior line of chemotherapy (*see Appendix B for examples*);
- 6. Request meets one of the following (a or b):*
 - a. Dose does not exceed 5.4 mg/kg every 3 weeks;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

D. Colon or Rectal Cancer (off label) (must meet all):

- 1. Diagnosis of advanced or metastatic colon or rectal cancer;
- 2. Prescribed by or in consultation with an oncologist;
- 3. Age \geq 18 years;
- 4. Documentation supports failure of or presence of clinically significant adverse effects or contraindication to at least two FDA approved medications for the relevant

diagnosis (e.g., oxaliplatin, irinotecan, FOLFOX [fluorouracil, leucovorin, and oxaliplatin] or CapeOX [capecitabine and oxaliplatin], bevacizumab);

5. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 6 months

E. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53

II. Continued Therapy

A. Cancer (must meet all):

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.LTSS.PHAR.01) applies;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a, b or c):
 - a. For breast cancer or NSCLC: New dose does not exceed 5.4 mg/kg every 3 weeks;
 - b. For gastric or GEJ adenocarcinoma: New dose does not exceed 6.4 mg/kg every 3 weeks;
 - c. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.LTSS.PHAR.01) applies.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – PA.CP.PMN.53

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

GEJ: gastroesophageal junction

HER2: human epidermal growth factor
receptor 2

HR: hormone-receptor

NCCN: National Comprehensive Center
Network

NSCLC: non-small cell lung cancer

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
HER2+ Breast Cancer NCCN examples of systemic therapies for recurrent or metastatic disease: <ul style="list-style-type: none"> • Aromatase inhibitor ± trastuzumab • Aromatase inhibitor ± lapatinib • Pertuzumab + trastuzumab + docetaxel 	Varies	Varies
Breast Cancer <ul style="list-style-type: none"> • Examples of systemic therapies include but are not limited to: eribulin, capecitabine, gemcitabine, nab-paclitaxel, paclitaxel Examples of endocrine therapies for HR+ disease include but are not limited to: sacituzumab, palbocicib, ribociclib, abemaciclib, tamoxifen, letrozole, anastrozole, exemestane	Varies	Varies
Gastric and Gastroesophageal Junction Cancer trastuzumab-based regimen	8 mg/kg IV followed by 6 mg/kg IV q 3 weeks	8 mg/kg
NSCLC Examples of systemic therapies include but are not limited to: <ul style="list-style-type: none"> • Carboplatin or cisplatin + pemetrexed + pembrolizumab • Carboplatin + paclitaxel + bevacizumab + atezolizumab • Carboplatin + albumin-bound paclitaxel + atezolizumab • Carboplatin + paclitaxel or albumin-bound paclitaxel + pembrolizumab • Nivolumab + ipilimumab + paclitaxel + carboplatin or cisplatin Examples of targeted therapies include but are not limited to: <ul style="list-style-type: none"> • EGFR mutation positive: afatinib, erlotinib, dacomitinib, gefitinib, osimertinib, erlotinib + ramucirumab, erlotinib + bevacizumab (non-squamous) • BRAF: dabrafenib/trametinib, dabrafenib, vemurafenib • ALK: alectinib, brigatinib, ceritinib, crizotinib, lorlatinib ROS1: ceritinib, crizotinib, entrectinib 	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<p>Examples of targeted therapies include but are not limited to:</p> <ul style="list-style-type: none"> EGFR mutation positive: afatinib, erlotinib, dacomitinib, gefitinib, osimertinib, erlotinib + ramucirumab, erlotinib + bevacizumab (non-squamous) BRAF: dabrafenib/trametinib, dabrafenib, vemurafenib ALK: alectinib, brigatinib, ceritinib, crizotinib, lorlatinib ROS1: ceritinib, crizotinib, entrectinib 		

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): interstitial lung disease and pneumonitis; embryo-fetal toxicity

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Breast cancer, NSCLC	5.4 mg/kg IV every 3 weeks	5.4 mg/kg
Gastric, GEJ cancer	6.4 mg/kg IV every 3 weeks	6.4 mg/kg

VI. Product Availability

Single-dose vial: 100 mg lyophilized powder

VII. References

- Enhertu Prescribing Information. Basking Ridge, NJ: Daiichi Sankyo, Inc.; November 2022. Available at: www.enhertu.com. Accessed November 15, 2022.
- National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed November 15, 2022.
- National Comprehensive Cancer Network. Breast Cancer Version 4.2022. Available at: http://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed November 15, 2022.
- Modi S, Saura C, Yamashita T, et al. Trastuzumab deruxtecan in previously treated HER2-positive breast cancer. *N Engl J Med*. 2019; doi: 10.1056/NEJMoa1914510.
- National Comprehensive Cancer Network. Gastric Cancer Version 2.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/gastric.pdf. Accessed November 15, 2022.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9358	Injection, fam-trastuzumab deruxtecan-nxki, 1 mg

Reviews, Revisions, and Approvals	Date
Policy created	10/2020
1Q 2021 annual review: recurrent breast cancer added per NCCN; added criteria for new FDA-approved gastric cancer indication; updated coding implications; therapeutic alternatives and references reviewed and updated	01/2021
1Q 2022 annual review: references reviewed and updated.	01/2022
1Q 2023 annual review: added criteria for new FDA-approved indications for NSCLC and HER2-low breast cancer, references reviewed and updated. added off-label use for advanced or metastatic colon and rectal cancers per NCCN; for NSCLC removed the criterion to require treatment of non-HER2 mutations first, to align with NCCN recommendations; added recurrent gastric or GEJ cancer as a covered indication per NCCN; RT4: added language to the FDA Approved Indications section re: using an FDA-approved test to identify HER2-low breast cancer; references reviewed and updated.	01/2023