POLICY Document for KANJINTI (trastuzumab-anns)

The overall objective of this policy is to support the appropriate and cost-effective use of the medication, specific to use of preferred medication options, and overall, clinically appropriate use. This document provides specific information to both sections of the overall policy.

Section 1: Preferred Product
- Policy information specific to preferred medications

Section 2: Clinical Criteria
- Policy information specific to the clinical appropriateness for the medication

Section 3: Oncology Clinical Policy
- Policy information specific to regimen review per NCCN Guidelines.

Section 1: Preferred Product

CAREFIRST: EXCEPTIONS CRITERIA
TRASTUZUMAB PRODUCTS

PREFERRED PRODUCTS: KANJINTI, TRAZIMERA

Client Requested: The intent of the criteria is to ensure that patients follow selection elements as established by CareFirst.

POLICY
This policy informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

I. PLAN DESIGN SUMMARY

This program applies to the trastuzumab products specified in this policy. Coverage for targeted product is provided based on clinical circumstances that would exclude the use of the preferred products. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with a targeted product.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Trastuzumab Products

	Product(s)
Preferred*	• **Kanjinti** (trastuzumab-anns) • **Trazimera** (trastuzumab-qyyp)
Targeted	• **Herceptin** (trastuzumab) • **Herceptin Hylecta** (trastuzumab and hyaluronidase-oysk) • **Hercessi (**trastuzumab-strf) • **Herzuma** (trastuzumab-pkrb)

	• **Ogivri** (trastuzumab-dkst) • **Ontruzant** (trastuzumab-dttb)

*: Medications considered formulary or preferred on your plan may still require a clinical prior authorization review

II. EXCEPTION CRITERIA

Coverage for a targeted product is provided when either of the following criteria is met:

A. Member has a documented inadequate response, contraindication, or intolerable adverse event to both preferred products and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products)

Section 2: Clinical Criteria

Specialty Guideline Management Herceptin and Trastuzumab Biosimilars

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Herceptin	trastuzumab
Ogivri	trastuzumab-dkst
Kanjinti	trastuzumab-anns
Trazimera	trastuzumab-qyyp
Herzuma	trastuzumab-pkrb
Ontruzant	trastuzumab-dttb
Hercessi	trastuzumab-strf

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

Adjuvant breast cancer

Adjuvant 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:

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

Metastatic breast cancer

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

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

Compendial Uses

- HER2-positive breast cancer
  - Neoadjuvant therapy
  - Treatment of recurrent, advanced, unresectable, or stage IV (M1) disease
  - Treatment for no response to preoperative systemic therapy
- Intra-cerebrospinal fluid (CSF) treatment for leptomeningeal metastases from HER2-positive breast cancer
- HER2-positive esophageal and esophagogastric junction cancer
- HER2-positive uterine serous carcinoma or carcinosarcoma
- HER2-amplified/positive and RAS and BRAF wild-type colorectal cancer
- HER2-positive salivary gland tumor
- HER2-positive biliary tract cancers

All other indications are considered experimental/investigational and not medically necessary.

Documentation

Submission of the following information is necessary to initiate the prior authorization review: human epidermal growth factor receptor 2 (HER2) status (where applicable), RAS mutation status (where applicable), BRAF mutation status (where applicable)

CVS/caremark

Coverage Criteria

Breast Cancer

- Authorization of up to 12 months may be granted for neoadjuvant treatment of HER2-positive breast cancer as part of a complete treatment regimen.
- Authorization of up to 12 months may be granted for adjuvant treatment of HER2-positive breast cancer.
- Authorization of 12 months may be granted for treatment of HER2-positive breast cancer with no response to preoperative systemic therapy, recurrent, advanced, unresectable, or metastatic (including brain metastases) disease.
- Authorization of 12 months may be granted for intra-CSF treatment for leptomeningeal metastases from HER2-positive breast cancer.

Esophageal, Gastric, or Gastroesophageal Junction Cancer

Authorization of 12 months may be granted for treatment or palliative therapy of HER2-positive esophageal, gastric, or gastroesophageal junction cancer in combination with chemotherapy.

Uterine Serous Carcinoma or Carcinosarcoma

Authorization of 12 months may be granted for treatment of HER2-positive stage III-IV, recurrent, or metastatic uterine serous carcinoma or carcinosarcoma in combination with carboplatin and paclitaxel and continued as a single agent for maintenance therapy.

Colorectal Cancer

Authorization of 12 months may be granted for treatment of unresectable, advanced, or metastatic colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma, when all of the following criteria are met:

- Member has HER2-positive/amplified disease
- The disease is negative (wild-type) for RAS (KRAS and NRAS) and BRAF mutations
- The requested medication will be used in combination with tucatinib, pertuzumab, or lapatinib
- Member has received prior therapy for the disease or is not appropriate for intensive therapy

Salivary Gland Tumor

Authorization of 12 months may be granted for treatment of recurrent, unresectable, or metastatic HER2-positive salivary gland tumors when used as a single agent or in combination with docetaxel or pertuzumab.

Biliary Tract Cancers

Authorization 12 months may be granted for subsequent treatment of unresectable, resected gross residual, or metastatic HER2-positive biliary tract cancers (including intrahepatic and

extrahepatic cholangiocarcinoma and gallbladder cancer) when used in combination with pertuzumab or tucatinib.

Continuation of Therapy

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen. Adjuvant and neoadjuvant treatment of breast cancer will be approved for a total of 12 months of therapy.

Section 3: Oncology Clinical Policy

PURPOSE

The purpose of this policy is to define the Novologix NCCN® Regimen Prior Authorization Program.

SCOPE

This policy applies to clients who have implemented the Novologix NCCN® Program as a part of their medical and/or pharmacy prior authorization solution.

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.[1] 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 Guidelines® and NCCN Compendium®. The NCCN Compendium lists the appropriate drugs and biologics as treatment options 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[2]

- Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
- Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
- Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is

appropriate.
• Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

POLICY

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.

PROCEDURE

This policy provides coverage of a regimen review when all of the following criteria are met:
1. Regimen prior authorization reviews, based on NCCN templates, are initiated through the provider portal.
- 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.
3. The member is eligible for regimen review.
4. The indication is for a cancer that is eligible for regimen review. Currently, the cancer types in scope for regimen review include the following:
    - Ampullary Adenocarcinoma
    - Anal Carcinoma
    - B-Cell Lymphomas
    - Basal Cell Skin Cancer
    - Biliary Tract Cancers
    - Bone Cancer
    - Breast Cancer
    - Bladder Cancer
    - Central Nervous System Cancers
    - Cervical Cancer
    - Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma
    - Chronic Myeloid leukemia
    - Colon Cancer
    - Dermatofibrosarcoma Protuberans
    - Esophageal Cancer
    - Gastric Cancer
    - Gastrointestinal Stromal Tumors
    - Gestational Trophoblastic Neoplasms
    - Hairy Cell Leukemia
    - Head and Neck Cancers
    - Histiocytic Neoplasms
    - Hodgkin Lymphoma

- Hepatocellular Carcinoma
- Kaposi Sarcoma
- Kidney Cancer
- Melanoma: Cutaneous
- Melanoma: Uveal
- Merkel Cell Carcinoma
- Mesothelioma: Peritoneal
- Mesothelioma: Pleural
- Multiple Myeloma
- Myelodysplastic Syndromes
- Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions
- Myeloproliferative Neoplasms
- Neuroendocrine and Adrenal Tumors
- Non-Small Cell Lung Cancer
- Occult Primary
- Ovarian Cancer
- Pancreatic Cancer
- Penile Cancer
- Primary Cutaneous Lymphomas
- Prostate Cancer
- Rectal Cancer
- Small Bowl Adenocarcinoma
- Small Cell Lung Cancer
- Soft Tissue Sarcoma
- Squamous Cell Skin Cancer
- Systemic Mastocytosis
- Systemic Light Chain Amyloidosis
- T-Cell Lymphomas
- Testicular Cancer
- Thymomas and Thymic Carcinomas
- Thyroid Carcinoma
- Uterine Neoplasms
- Vaginal Cancer
- Vulvar Cancer
- Waldenström Macroglobulinemia / Lymphoplasmacytic Lymphoma
- Wilms Tumor (Nephroblastoma)

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.

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

Authorizations may be granted for 12 months or as medically required, based on the member's condition

and provider's assessment.

Supportive Care: Myeloid Growth Factor Therapy
Granulocyte colony stimulating factors are recommended for primary prophylaxis based on the febrile neutropenia risk of the chemotherapy regimen. Febrile neutropenia risk levels vary by NCCN Chemotherapy Order template and are listed at the top of the template. Regimens associated with a high or intermediate risk of febrile neutropenia may include a granulocyte colony stimulating factor as part of the prior authorization.

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 evidence-based practice guidelines.

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SECTION 3

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