Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk) (Subcutaneous)

Document Number: IC-0449

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I. Length of Authorization

Coverage is provided for six months and may be renewed.

- Use in the adjuvant setting is limited to a total of 52 weeks of treatment.

II. Dosing Limits

A. Quantity Limit (max daily dose) [Pharmacy Benefit]:

– Herceptin Hylecta 600 mg/10,000 units single-dose vial: 1 vial every 21 days

B. Max Units (per dose and over time) [Medical Benefit]:

Breast Cancer

- 60 billable units every 21 days

III. Initial Approval Criteria

Coverage is provided in the following conditions:

- Baseline left ventricular ejection fraction (LVEF) within normal limits; **AND**
- Patient is 18 years or older; **AND**
- Patient's cancer is human epidermal growth factor receptor 2 (HER2)-overexpressing*****; **AND**
- Will not be used in combination with trastuzumab or ado-trastuzumab emtansine; **AND**
- Herceptin Hylecta will not be used with intravenous chemotherapy agents; **AND**

Breast cancer †

- Used as adjuvant therapy as a single agent following anthracycline-based therapy †; **OR**
- Used for metastatic disease as a single agent in patients who have received one or more prior treatments for metastatic disease †

† FDA Approved Indication(s); ‡ Compendia recommended Indication(s)

***HER2-positive overexpression criteria:**

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- Immunohistochemistry (IHC) assay 3+; **OR**
- In situ hybridization (ISH) assay average HER2 copy number ≥ 6.0 signals/cell; **OR**
- Dual-probe in situ hybridization (ISH) assay HER2/CEP17 ratio ≥ 2.0

IV. Renewal Criteria

Coverage can be renewed based upon the following criteria:

- Patient continues to meet the criteria identified in section III; **AND**
- Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: cardiotoxicity (e.g., left ventricular dysfunction, cardiomyopathy, etc.), pulmonary toxicity (i.e., pneumonitis), neutropenia, infusion-related reactions, etc.; **AND**
  - LVEF has not had an absolute decrease of ≥ 16% from pre-treatment baseline and is within the institutional normal limits; **OR**
  - LVEF has not had an absolute decrease of ≥ 10% from pre-treatment baseline and is below the institutional lower limits of normal; **AND**
- For the adjuvant treatment of breast cancer, the patient has not exceeded a maximum of 52 weeks of therapy

V. Dosage/Administration

Indication	Dose
Breast Cancer	Administer* 600 mg/10,000 units (600 mg trastuzumab and 10,000 units hyaluronidase) subcutaneously over approximately 2-5 minutes once every three weeks. * *Herceptin Hylecta should be administered by healthcare professional.*
Note: Do not substitute Herceptin Hylecta for or with ado-trastuzumab emtansine.	

VI. Billing Code/Availability Information

Jcode:

- J9999 – Not otherwise classified, antineoplastic drugs
- C9399 – Unclassified drugs or biologicals
- J9356 – Injection, trastuzumab, 10 mg and Hyaluronidase-oysk: 1 billable unit = 10 mg *(Effective 7/1/2019)*

NDC:

- Herceptin Hylecta 600 mg/10,000 units (providing 600 mg trastuzumab and 10,000 units hyaluronidase per 5 mL) single-dose vials: 50242-0077-xx

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VII. References

1. Herceptin Hylecta [package insert]. South San Francisco, CA; Genentech, Inc; February 2019. Accessed May 2019.
2. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) trastuzumab and hyaluronidase human. National Comprehensive Cancer Network, 2019. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc." To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed May 2019.

Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.012	Malignant neoplasm of nipple and areola, left female breast
C50.019	Malignant neoplasm of nipple and areola, unspecified female breast
C50.021	Malignant neoplasm of nipple and areola, right female breast
C50.022	Malignant neoplasm of nipple and areola, left female breast
C50.029	Malignant neoplasm of nipple and areola, unspecified female breast
C50.111	Malignant neoplasm of central portion of right female breast
C50.112	Malignant neoplasm of central portion of left female breast
C50.119	Malignant neoplasm of central portion of unspecified female breast
C50.121	Malignant neoplasm of central portion of right male breast
C50.122	Malignant neoplasm of central portion of left male breast
C50.129	Malignant neoplasm of central portion of unspecified male breast
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
C50.219	Malignant neoplasm of upper-inner quadrant of unspecified female breast
C50.221	Malignant neoplasm of upper-inner quadrant of right male breast
C50.222	Malignant neoplasm of upper-inner quadrant of left male breast
C50.229	Malignant neoplasm of upper-inner quadrant of unspecified male breast
C50.311	Malignant neoplasm of lower-inner quadrant of right female breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
C50.319	Malignant neoplasm of lower-inner quadrant of unspecified female breast
C50.321	Malignant neoplasm of lower-inner quadrant of right male breast
C50.322	Malignant neoplasm of lower-inner quadrant of left male breast
C50.329	Malignant neoplasm of lower-inner quadrant of unspecified male breast

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ICD-10	ICD-10 Description
C50.411	Malignant neoplasm of upper-outer quadrant of right female breast
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
C50.419	Malignant neoplasm of upper-outer quadrant of unspecified female breast
C50.421	Malignant neoplasm of upper-outer quadrant of right male breast
C50.422	Malignant neoplasm of upper-outer quadrant of left male breast
C50.429	Malignant neoplasm of upper-outer quadrant of unspecified male breast
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
C50.519	Malignant neoplasm of lower-outer quadrant of unspecified female breast
C50.521	Malignant neoplasm of lower-outer quadrant of right male breast
C50.522	Malignant neoplasm of lower-outer quadrant of left male breast
C50.529	Malignant neoplasm of lower-outer quadrant of unspecified male breast
C50.611	Malignant neoplasm of axillary tail of right female breast
C50.612	Malignant neoplasm of axillary tail of left female breast
C50.619	Malignant neoplasm of axillary tail of unspecified female breast
C50.621	Malignant neoplasm of axillary tail of right male breast
C50.622	Malignant neoplasm of axillary tail of left male breast
C50.629	Malignant neoplasm of axillary tail of unspecified male breast
C50.811	Malignant neoplasm of overlapping sites of right female breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
C50.819	Malignant neoplasm of overlapping sites of unspecified female breast
C50.821	Malignant neoplasm of overlapping sites of right male breast
C50.822	Malignant neoplasm of overlapping sites of left male breast
C50.829	Malignant neoplasm of overlapping sites of unspecified male breast
C50.911	Malignant neoplasm of unspecified site of right female breast
C50.912	Malignant neoplasm of unspecified site of left female breast
C50.919	Malignant neoplasm of unspecified site of unspecified female breast
C50.921	Malignant neoplasm of unspecified site of right male breast
C50.922	Malignant neoplasm of unspecified site of left male breast
C50.929	Malignant neoplasm of unspecified site of unspecified male breast
Z85.3	Personal history of malignant neoplasm of breast

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage

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Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA,HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC

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