



Perjeta® (pertuzumab)

(Intravenous)

-E-

Document Number: IC-0387

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05/2021, 07/2021, 10/2021, 02/2022, 05/2022, 07/2022

I. Length of Authorization ¹

Coverage is provided for 6 months and may be renewed (unless otherwise specified).

• Neoadjuvant and adjuvant treatment in Breast Cancer may be authorized up to a maximum of 1 year of treatment [18 cycles].

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

Perjeta 420 mg/14mL solution for injection:

- Loading Dose: 2 vials
- Maintenance Dose: 1 vial every 21 days

B. Max Units (per dose and over time) [HCPCS Unit]:

- Loading Dose: 840 billable units x 1 dose
- **Maintenance Dose**: 420 billable units every 21 days

III. Initial Approval Criteria 1

Coverage is provided in the following conditions:

• Patient is at least 18 years of age; AND

Universal Criteria 1

- Left ventricular ejection fraction (LVEF) is within normal limits prior to initiating therapy and will be assessed at regular intervals (e.g., every 3 months) during treatment; **AND**
- Patient has human epidermal growth factor receptor 2 (HER2)-positive* disease as determined by an FDA-approved or CLIA-compliant test*; AND
- Therapy will not be used in combination with pertuzumab/trastuzumab and hyaluronidasezzxf (Phesgo); AND

Breast Cancer † 1-3,5-8,13,12e-15e,24e-26e

• Used as adjuvant treatment; AND

- o Patient has node-positive (N1-N3) disease; AND
- o Used in combination with a trastuzumab-based regimen; OR
- Used as neoadjuvant (or preoperative treatment); AND
 - o Patient has locally advanced, node positive, or inflammatory disease; AND
 - Used in combination with trastuzumab and a taxane-based regimen (e.g., docetaxel, paclitaxel, etc.); **OR**
- Used for recurrent unresectable or metastatic disease; AND
 - Used as first-line therapy in combination with trastuzumab and either paclitaxel OR docetaxel; OR
 - Used as subsequent therapy in combination with a trastuzumab-based regimen ‡; AND
 - Patient was previously treated with trastuzumab and chemotherapy; AND
 - Patient has not previously received pertuzumab; AND

Subsequent therapy in combination with a trastuzumab-based regimen (does NOT apply to second-line therapy):

Use of pertuzumab in combination with a trastuzumab-based regimen will be restricted to patients with a contraindication or intolerance to lapatinib/capecitabine, trastuzumab/lapatinib, or a regimen containing trastuzumab in combination with a generically available agent/regimen (e.g., trastuzumab/capecitabine, etc. [see NCCN Breast Cancer guidelines for complete list of alternative regimens])

Colorectal Cancer ‡ 2,9-12,16e

- Used for RAS and BRAF wild-type (WT) disease in combination with trastuzumab; AND
- Patient has not previously received HER2-targeted therapy; AND
- Used as subsequent therapy for progression of advanced or metastatic disease after at least one prior line of treatment in the advanced or metastatic disease setting; **AND**
- Use of pertuzumab will be restricted to patients with a contraindication or intolerance to trastuzumab/lapatinib (if not previously used)

Head and Neck Cancer ‡ 2,14,15,20e

- Patient has salivary gland tumors; AND
- Used in combination with trastuzumab; AND
- Used for one of the following:
 - o Recurrent disease with distant metastases
 - Unresectable locoregional recurrence with prior radiation therapy (RT)
 - o Unresectable second primary with prior RT; AND



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• Use of pertuzumab will be restricted to patients with a contraindication or intolerance to trastuzumab/docetaxel (if not previously used)

Hepatobiliary Cancers ‡ 2,16,17

- Patient has gallbladder cancer, extrahepatic cholangiocarcinoma, or intrahepatic cholangiocarcinoma; **AND**
- Used as subsequent treatment for progression on or after systemic treatment for unresectable or metastatic disease; AND
- Used in combination with trastuzumab

Preferred therapies and recommendations are determined by review of clinical evidence. NCCN category of recommendation is taken into account as a component of this review. Regimens deemed equally efficacious (i.e., those having the same NCCN categorization) are considered to be therapeutically equivalent.

*HER2-positive overexpression criteria:

Breast, Head and Neck, and Hepatobiliary Cancer: 3,4

- Immunohistochemistry (IHC) assay 3+; OR
- Dual-probe in situ hybridization (ISH) assay HER2/CEP17 ratio ≥ 2.0 AND average HER2 copy number ≥ 4.0 signals/cell; **OR**
- Dual-probe in situ hybridization (ISH) assay AND concurrent IHC indicating one of the following:
 - HER2/CEP17 ratio ≥ 2.0 AND average HER2 copy number < 4.0 signals/cell AND concurrent IHC 3+;
 OR
 - HER2/CEP17 ratio < 2.0 AND average HER2 copy number ≥ 6.0 signals/cell AND concurrent IHC 2+ or 3+; OR</p>
 - HER2/CEP17 ratio < 2.0 AND average HER2 copy number ≥ 4.0 and < 6.0 signals/cell AND concurrent IHC 3+

Colorectal Cancer: 10,11

- Immunohistochemistry (IHC) assay 3+; OR
- Fluorescence in situ hybridization (FISH) HER2/CEP17 ratio ≥ 2 AND concurrent IHC 2+; **OR**
- Next-generation sequencing (NGS) panel HER2 amplification
- ❖ If confirmed using an immunotherapy assay-http://www.fda.gov/companiondiagnostics
- † FDA Approved Indication(s); ‡ Compendia recommended indication(s); ♠ Orphan Drug

IV. Renewal Criteria 1

Coverage may be renewed based upon the following criteria:



- Patient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. 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: left ventricular dysfunction, severe infusion-related reactions, hypersensitivity reactions/anaphylaxis, etc.; AND
- Left ventricular ejection fraction (LVEF) obtained within the previous 3 months as follows:
 - Neoadjuvant and adjuvant treatment of breast cancer: LVEF is ≥ 50% OR LVEF has had an <u>absolute</u> decrease of < 10% from baseline
 - All other indications: LVEF is > 45% OR LVEF is 40% to 45% and absolute decrease is < 10% from baseline; AND

Breast Cancer (neoadjuvant or adjuvant therapy)

Patient has not exceeded a maximum of 1 year of treatment (total of 18 cycles)

Dosage/Administration 1,10-13,15,16 ٧.

| Indication | Dose | |
|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Breast Cancer | Administer 840 mg intravenously x 1 dose, then 420 mg intravenously every 21 days thereafter until disease progression or unmanageable toxicity | |
| | Neoadjuvant therapy consists of 3 to 6 cycles prior to surgery. | |
| | • Use for neoadjuvant and adjuvant treatment is limited to a total of 1 year of treatment (total of 18 cycles). | |
| | *Note: When used for recurrent or metastatic breast cancer, therapy may be continued until disease progression or unmanageable toxicity. | |
| All other indications | Administer 840 mg intravenously x 1 dose, then 420 mg intravenously every 21 days thereafter until disease progression or unmanageable toxicity | |

VI. **Billing Code/Availability Information**

HCPCS Code:

• J9306 - Injection, pertuzumab, 1 mg; 1 mg = 1 billable unit

NDC:

• Perjeta 420 mg/14 mL solution for injection: 50242-0145-xx

VII. **References (STANDARD)**

1. Perjeta [package insert]. South San Francisco, CA; Genentech, Inc.; February 2021. Accessed May 2022.



without approval.

- 2. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) pertuzumab. National Comprehensive Cancer Network, 2022. 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 2022.
- 3. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) Breast Cancer, Version 3.2022. National Comprehensive Cancer Network, 2022. 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 NCCN Guidelines, go online to NCCN.org. Accessed May 2022.
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- 11. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Rectal Cancer, Version 1.2022. National Comprehensive Cancer Network, 2022. 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 Guidelines, go online to NCCN.org. Accessed May 2022.



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Appendix 1 – Covered Diagnosis Codes

| ICD-10 | ICD-10 Description | |
|---------|------------------------------------------------------------------------|--|
| C06.9 | Malignant neoplasm of mouth, unspecified | |
| C07 | Malignant neoplasm of parotid gland | |
| C08.0 | Malignant neoplasm of submandibular gland | |
| C08.1 | Malignant neoplasm of sublingual gland | |
| C08.9 | Malignant neoplasm of major salivary gland, unspecified | |
| C18.0 | Malignant neoplasm of cecum | |
| C18.1 | Malignant neoplasm of appendix | |
| C18.2 | Malignant neoplasm of ascending colon | |
| C18.3 | Malignant neoplasm of hepatic flexure | |
| C18.4 | Malignant neoplasm of transverse colon | |
| C18.5 | Malignant neoplasm of splenic flexure | |
| C18.6 | Malignant neoplasm of descending colon | |
| C18.7 | Malignant neoplasm of sigmoid colon | |
| C18.8 | Malignant neoplasm of overlapping sites of large intestines | |
| C18.9 | Malignant neoplasm of colon, unspecified | |
| C19 | Malignant neoplasm of rectosigmoid junction | |
| C20 | Malignant neoplasm of rectum | |
| C21.8 | Malignant neoplasm of overlapping sites of rectum, anus and anal canal | |
| C22.1 | Intrahepatic bile duct carcinoma | |
| C23 | Malignant neoplasm of gallbladder | |
| C24.0 | Malignant neoplasm of extrahepatic bile duct | |
| C24.8 | Malignant neoplasm of overlapping sites of biliary tract | |
| C24.9 | Malignant neoplasm of biliary tract, unspecified | |
| 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 male breast | |
| C50.022 | Malignant neoplasm of nipple and areola, left male breast | |
| C50.029 | Malignant neoplasm of nipple and areola, unspecified male breast | |

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| ICD-10 | ICD-10 Description | |
|---------|-------------------------------------------------------------------------|--|
| 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 | |
| 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 | |



| ICD-10 | ICD-10 Description | |
|---------|----------------------------------------------------------------------|--|
| 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 | |
| C78.00 | Secondary malignant neoplasm of unspecified lung | |
| C78.01 | Secondary malignant neoplasm of right lung | |
| C78.02 | Secondary malignant neoplasm of left lung | |
| C78.6 | Secondary malignant neoplasm of retroperitoneum and peritoneum | |
| C78.7 | Secondary malignant neoplasm of liver and intrahepatic bile duct | |
| Z85.038 | Personal history of other malignant neoplasm of large intestine | |

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 Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/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/LCA): 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. | | |



| Medicare Part B Administrative Contractor (MAC) Jurisdictions | | | | |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------|--|--|
| Jurisdiction | Applicable State/US Territory | Contractor | | |
| 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 | | |

