

## Phesgo™ (pertuzumab, trastuzumab and hyaluronidase-zzxf) (Subcutaneous)

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### I. Length of Authorization <sup>1</sup>

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

- Neoadjuvant and adjuvant therapy may be authorized for a total of 1 year (up to 18 cycles).

### II. Dosing Limits

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

- Phesgo (1,200 mg pertuzumab/600 mg trastuzumab/30,000 units hyaluronidase) single-dose vial: 1 vial as initial dose
- Phesgo (600 mg pertuzumab/600 mg trastuzumab/20,000 units hyaluronidase) single-dose vial: 1 vial every 21 days

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

- Initial Dose: 180 billable units x 1 dose
- Maintenance Dose: 120 billable units every 21 days

### III. Initial Approval Criteria <sup>1-5</sup>

Coverage is provided in the following conditions:

- Patient is at least 18 years of age; **AND**

#### Universal Criteria <sup>1</sup>

- 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 (or trastuzumab biosimilar product [e.g., Ogivri, Kanjinti, Trazimera, Herzuma, Ontruzant]), or trastuzumab and hyaluronidase-oysk (Herceptin Hylecta); **AND**

- Therapy will not be substituted for or with pertuzumab or any trastuzumab-based formulation (i.e., trastuzumab [or trastuzumab biosimilar product], ado-trastuzumab emtansine, fam-trastuzumab deruxtecan-nxki, trastuzumab-hyaluronidase, etc.); **AND**

### **Breast Cancer †<sup>1-7,1e-4e,7e,16e-19e</sup>**

- Used as neoadjuvant therapy; **AND**
  - Patient has locally advanced, inflammatory, or early stage disease (i.e., tumor size >2 cm in diameter or node positive); **OR**
- Used as adjuvant therapy; **AND**
  - Patient has node-positive (N1-N3) disease; **OR**
- Used for recurrent unresectable or metastatic disease; **AND**
  - Used as first-line therapy in combination with either paclitaxel or docetaxel; **OR**
  - Used as subsequent therapy ‡; **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, trastuzumab and hyaluronidase-zzxf will be restricted to patients with a contraindication or intolerance to lapatinib/capecitabine 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])

**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.**

❖ *If confirmed using an immunotherapy assay* <http://www.fda.gov/companiondiagnostics>

† FDA Approved Indication(s); ‡ Compendia recommended Indication(s); Ⓞ Orphan Drug

#### **\*HER2-positive overexpression criteria:<sup>6,7</sup>**

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

- HER2/CEP17 ratio < 2.0 AND average HER2 copy number ≥ 4.0 and < 6.0 signals/cell AND concurrent IHC 3+

#### IV. Renewal Criteria <sup>1</sup>

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: cardiotoxicity (e.g., left ventricular dysfunction, cardiomyopathy), pulmonary toxicity (e.g., interstitial pneumonitis), neutropenia, severe infusion-related reactions (e.g., hypersensitivity reactions, anaphylaxis), etc.; **AND**
- Left ventricular ejection fraction (LVEF) within the previous 3 months as follows:
  - Neoadjuvant and adjuvant breast cancer: LVEF is ≥ 50% OR LVEF has had an absolute decrease of < 10% from pre-treatment baseline; **OR**
  - All other indications: LVEF is > 45% OR LVEF is 40% to 45% and absolute decrease is < 10% from pre-treatment baseline

#### Breast Cancer (neoadjuvant or adjuvant treatment)

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

#### V. Dosage/Administration

Indication	Dose
Breast Cancer	<b><u>Initial Dose</u></b> Administer 1,200 mg pertuzumab/600 mg trastuzumab/30,000 units hyaluronidase subcutaneously
	<b><u>Maintenance Dose</u></b> Administer 600 mg pertuzumab/600 mg trastuzumab/20,000 units hyaluronidase subcutaneously every 3 weeks
	○ Neoadjuvant therapy: administer for 3-6 cycles initially, then continue following surgery to complete 1 year of treatment (up to 18 cycles) or until disease recurrence or unacceptable toxicity
	○ Adjuvant therapy: administer for a total of 1 year (up to 18 cycles) or until disease recurrence or unacceptable toxicity
	○ Recurrent or metastatic breast cancer: administer until disease progression or until unacceptable toxicity
<b><u>Note:</u></b>	

- *To be administered by a health care professional for subcutaneous use only in the thigh. Do not administer intravenously.*
- *Phesgo has different dosage and administration instructions than intravenous pertuzumab, intravenous trastuzumab, and subcutaneous trastuzumab when administered alone.*
- *Refer to the package insert for timing and sequence of dosing with other chemotherapy.*
- *Refer to the package insert for transitioning from trastuzumab and/or pertuzumab intravenous.*

## VI. Billing Code/Availability Information

### HCPCS Code:

- J9316 – Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg; 1 billable unit = 10 mg

### NDC(s):

- Phesgo (1,200 mg pertuzumab, 600 mg trastuzumab, and 30,000 units hyaluronidase per 15 mL) single-dose vial: 50242-0245-xx
- Phesgo (600 mg pertuzumab, 600 mg trastuzumab, and 20,000 units hyaluronidase per 10 mL) single-dose vial: 50242-0260-xx

## VII. References (STANDARD)

1. Phesgo [package insert]. South San Francisco, CA; Genentech, Inc; June 2020. Accessed April 2022.
2. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) pertuzumab, trastuzumab and hyaluronidase human. 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 April 2022.
3. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Breast Cancer 2.2022. 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 April 2022.
4. Wolff AC, Hammond EH, Allison KH, et al. Human epidermal growth factor receptor 2 testing in breast cancer: American Society of Clinical Oncology/College of American Pathologists Clinical Practice Guideline Focused Update. *J Clin Oncol* 2018;36:2105-2122.
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## VIII. References (ENHANCED)

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## 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
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

ICD-10	ICD-10 Description
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

## 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.
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