Clinical Policy: Pertuzumab/Trastuzumab/Hyaluronidase-zzxf (Phesgo)

Reference Number: PA.CP.PHAR.501
Effective Date: 10/2020
Last Review Date: 07/2024

Description

Pertuzumab/trastuzumab/hyaluronidase-zzxf (Phesgo™) is a fixed-dose subcutaneous formulation of human epidermal growth factor 2 (HER2)/neu receptor antagonists [Perjeta® (pertuzumab) and Herceptin® (trastuzumab)] and endoglycosidase (hyaluronidase).

FDA Approved Indication(s)

Phesgo is indicated for:

- Use in combination with chemotherapy as:
  - Neoadjuvant treatment of patients with HER2-positive, locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive) as part of a complete treatment regimen for early breast cancer
  - Adjuvant treatment of patients with HER2-positive early breast cancer at high risk of recurrence
- Use in combination with docetaxel for treatment of patients with HER2-positive metastatic breast cancer (MBC) who have not received prior anti-HER2 therapy or chemotherapy for metastatic disease

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 Phesgo is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Breast Cancer (must meet all)**:**

1. Diagnosis of HER2-positive breast cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed in combination with chemotherapy (*see Appendix B)*;
5. Request meets one of the following (a or b):
   a. Dose does not exceed an initial dose of 1,200 mg pertuzumab, 600 mg trastuzumab, and 30,000 units hyaluronidase (one single-dose vial), followed by 600 mg pertuzumab, 600 mg trastuzumab, and 20,000 units hyaluronidase (one single-dose vial) every three weeks;
   For missed or delayed doses, if the interval between two sequential injections is 6 weeks or more, re-administration of the initial dose of 1,200 mg pertuzumab, 600 mg trastuzumab, and 30,000 units hyaluronidase (one single-dose vial) is appropriate, followed by 600 mg pertuzumab, 600 mg trastuzumab, and 20,000 units hyaluronidase (one single-dose vial) every three 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. 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. Breast 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.PHARM.01) applies;
2. Member is responding positively to therapy;
3. If request is for use of Phesgo as neoadjuvant therapy, the member has not already received more than 6 cycles of therapy;
4. If request is for use of Phesgo as adjuvant therapy, the member has not already received more than 18 cycles of therapy;
5. If request is for a dose increase, request meets one of the following (a or b):
   a. New dose does not exceed 600 mg pertuzumab, 600 mg trastuzumab, and 20,000 units hyaluronidase (one single-dose vial) every three weeks;
   For missed or delayed doses, if the interval between two sequential injections is 6 weeks or more, re-administration of the initial dose of 1,200 mg pertuzumab, 600 mg trastuzumab, and 30,000 units hyaluronidase (one single-dose vial) is appropriate, followed by 600 mg pertuzumab, 600 mg trastuzumab, and 20,000 units hyaluronidase (one single-dose vial) every three weeks.
   b. 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.PHARM.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
HER2: human epidermal growth factor 2
MBC: metastatic breast cancer
NCCN: National Comprehensive Cancer Network

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Examples of drugs that may be used with Phesgo for breast cancer: • Chemotherapeutic agents: carboplatin, cyclophosphamide, doxocrubicin • HER2-targeted agents: docetaxel (Taxotere®), paclitaxel • Endocrine therapy: tamoxifen; aromatase inhibitors: anastrozole (Arimidex®), letrozole (Femara®), exemestane (Aromasin®).	Regimens are dependent on a variety of factors including menopausal status, treatment/progression history, clinical stage, histology, mutational and receptor status, treatment purpose (e.g., adjuvant and neoadjuvant treatment, treatment for metastatic disease).	Varies

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): known hypersensitivity to pertuzumab, or trastuzumab, or hyaluronidase, or to any of its excipients
- Boxed warning(s): cardiomyopathy, embryo-fetal toxicity, and pulmonary toxicity

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Breast cancer	Initial dose of 1,200 mg pertuzumab, 600 mg trastuzumab, and 30,000 units hyaluronidase administered SC in the thigh, followed by maintenance dose of 600 mg pertuzumab, 600 mg trastuzumab, and 20,000 units hyaluronidase administered SC in the thigh every 3 weeks • *For neoadjuvant*: administer by SC injection with chemotherapy by IV infusion preoperatively for 3 to 6 cycles for a total of one year • *For adjuvant*: administer by SC injection with chemotherapy by IV infusion postoperatively for a total of one year (up to 18 cycles) • *For metastatic disease*: administer with IV infusion of docetaxel Must be administered by a healthcare professional.	See regimens

VI. Product Availability

Single-dose vial for injection:

- 1,200 mg pertuzumab, 600 mg trastuzumab, and 30,000 units hyaluronidase per 15 mL (80 mg, 40 mg, and 2,000 units/mL)
- 600 mg pertuzumab, 600 mg trastuzumab, and 20,000 units hyaluronidase per 10 mL (60 mg, 60 mg, and 2,000 units/mL)

VII. References

1. Phesgo Prescribing Information. South San Francisco, CA: Genentech, Inc.; June 2020. Available at: https://www.phesgo.com/hcp.html. Accessed May 23, 2024.
2. Tan AR, Im SA, Mattar A, et al. Abstract PD4-07: subcutaneous administration of the fixed-dose combination of trastuzumab and pertuzumab in combination with chemotherapy in HER2-positive early breast cancer: primary analysis of the phase III, multicenter, randomized, open-label, two-arm FeDeriCa study. *Cancer Res.* 2020; 80(4): PD4-07; doi: 10.1158/1538-7445.SABCS19-PD4-07.
3. National Comprehensive Cancer Network Guidelines. Breast Cancer Version 2.2022. Available at www.nccn.org. Accessed May 22, 2024.
4. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed May 23, 2024.

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
J9316	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg

Reviews, Revisions, and Approvals	Date
Policy created	10/2020
3Q 2021 annual review: no significant changes; references reviewed and updated.	07/2021
3Q 2022 annual review: no significant changes; references reviewed and updated.	07/2022
3Q 2023 annual review: no significant changes; for Continued Therapy added criteria to document whether Phesgo is being used as neoadjuvant or adjuvant therapy in order to determine the appropriate total treatment duration; references reviewed and updated.	07/2023
3Q 2024 annual review: no significant changes; references reviewed and updated.	07/2024