

***Title: trastuzumab (Herceptin)***

<b>Origination:</b> 07/28/10	<b>Revised:</b> 09/08/10	<b>Annual Review:</b> 12/15/11
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**Purpose:**

To provide guidelines and criteria for the review and decision determination of requests for medications that requires prior authorization.

**Background Information:**

***Medication Summary***

- Trastuzumab (rhMAb HER2) is a recombinant DNA-derived humanized monoclonal antibody against the HER2 protein and is indicated for the treatment of metastatic breast carcinomas that overexpress HER2. HER2 overexpression is seen in 25—30% of breast cancers and is associated with aggressive disease and decreased overall survival. Use of trastuzumab should be limited to patients with documented overexpression of the HER2 protein (3+).
- Herceptin is indicated as:
  - Adjuvant treatment of HER2 overexpressing node positive or node negative breast cancer
  - First-line treatment of HER2-overexpressing metastatic breast cancer in combination with paclitaxel;
  - Single agent for treatment of HER2-overexpressing breast cancer in patients who have received one or more chemotherapy regimens for metastatic disease.
- Recommended doses include:
  - **Adjuvant treatment, Breast cancer:** Total of 52 weeks of Herceptin therapy:
    1. During and following paclitaxel, docetaxel, or docetaxel/carboplatin: initial dose of 4mg/kg as an IV infusion over 90minutes then at 2mg/kg as an IV infusion over 30 minutes weekly during chemotherapy for the first 12 weeks (paclitaxel or docetaxel) or 18 weeks (docetaxel/carboplatin);
    2. As a single agent within three (3) weeks following completion of multi-modality, anthracycline-based chemotherapy recommend an initial dose at 8mg/kg as an IV infusion over 90 minutes with subsequent doses at 6mg/kg as IV infusion over 30 minutes every 3 weeks.
  - **Metastatic treatment, Breast cancer:** Administer Herceptin, alone or in combination with paclitaxel, at an initial dose of 4mg/kg as a 90 minute IV infusion followed by subsequent once weekly doses of 2mg/kg as 30minute IV infusions until disease progression.

***Title: trastuzumab (Herceptin)***

**Background Information, continued:**

***Reference Statement***

- Guidelines are compiled from available US Food and Drug Administration (FDA) approved indications, general practice guidelines, and/or evidence-based uses established through phase III clinical studies without published conflicting data. Only clinical studies published in their entirety in reputable peer-reviewed journals will be evaluated.

***Eligibility Criteria***

- Member must be eligible and have applicable benefit coverage (i.e., self-injectable rider) within the specified date(s) of service.
- Prior authorization requests that do not meet clinical criteria in this Procedure will be forwarded to a Clinical Pharmacist for review.

**Procedure:**

- 1.0 Request for *initial therapy* with Herceptin for **adjuvant treatment of patients with human epidermal growth factor receptor 2 (HER2) overexpressing breast cancer OR for the treatment of HER2 overexpressing metastatic breast cancer** requires documentation from the Member's medical; records maintained by the requesting independent practitioner verifying the following:
  - 1.1 HER2 Overexpression defined by:
    - 1.1.1 Immunohistochemistry (IHC) assay 3+; **OR**
    - 1.1.1 Fluorescence in situ hybridization (FISH) >2.2;
    - 1.1.2 If IHC is 2+, must confirm with FISH assay of >2.2.
- 2.0 Request for *initial therapy* with Herceptin for **HER2 overexpressing advanced gastric cancer** requires documentation from the Member's medical; records maintained by the requesting independent practitioner verifying **HER2 over-expression**:
  - 2.1 HER2 Over-expression defined by:
    - 2.1.1 Immunohistochemistry (IHC) assay 3+; **OR**
    - 2.1.1 Fluorescence in situ hybridization (FISH) >2.2;
    - 2.1.2 If IHC is 2+, must confirm with FISH assay of >2.2.

**Procedure, continued:**

***Title: trastuzumab (Herceptin)***

- 3.0 Request for *initial therapy* with Herceptin for **HER2 overexpressing advanced esophageal cancer** requires documentation from the Member's medical; records maintained by the requesting independent practitioner verifying **HER2 over-expression:**
- 3.1 HER2 Over-expression defined by:
- 3.1.1 Immunohistochemistry (IHC) assay 3+; **OR**
- 3.1.1 Fluorescence in situ hybridization (FISH) >2.2;
- 3.1.2 If IHC is 2+, must confirm with FISH assay of >2.2.
- 4.0 Request for *continuation of therapy* with Herceptin for **all above indications** requires documentation from the Member's medical records maintained by the requesting independent practitioner verifying **tumor response**.

**References:**

1. Herceptin (trastuzumab) Prescribing Information. Genentech, Inc. San Francisco, CA. Rev June 2008.
2. Facts and Comparisons 4.0, St. Louis, MO. Walters Kluwer Health URL: [www.factsandcomparisons.com](http://www.factsandcomparisons.com). Updated 2010.
3. National Comprehensive Cancer Network, Inc. (NCCN) Practice Guidelines in Oncology Version 2.2010, March 2010. Available at: [www.nccn.org/professionals/physician\\_gls/f\\_guidelines.asp](http://www.nccn.org/professionals/physician_gls/f_guidelines.asp)

**Disclaimer Information:**

Prior Authorization criteria are developed to determine coverage for AvMed Health Plans' benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed Health Plans makes coverage decisions based on the Member's benefit plan contract and these criteria. This guideline sets forth concise clinical coverage criteria which have been developed from a review of current literature, policies of the FDA and other government agencies, and other appropriate references, in consultation and with approval from practicing physicians who are members of AvMed's Pharmacy and Therapeutic committee. Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change. The use of these criteria is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.