Clinical Policy: Ado-Trastuzumab Emtansine (Kadcyla)

Reference Number: ERX.SPA.41
Effective Date: 07.01.16
Last Review Date: 05.22
Line of Business: Commercial, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Ado-trastuzumab emtansine (Kadcyla®) is a human epidermal growth factor receptor 2 protein (HER2)-targeted antibody and microtubule inhibitor conjugate.

FDA Approved Indication(s)

Kadcyla is indicated as a single agent for the:

- Adjuvant treatment of patients with HER2-positive early breast cancer who have residual invasive disease after neoadjuvant taxane and trastuzumab-based treatment.
- Treatment of patients with HER2-positive, metastatic breast cancer who previously received trastuzumab and a taxane, separately or in combination. Patients should have either:
  - Received prior therapy for metastatic disease, or
  - Developed disease recurrence during or within six months of completing adjuvant therapy.

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.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Kadcyla 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 as a single agent;
5. Documentation of prior use of trastuzumab-based therapy and a taxane;
   **Prior authorization may be required for these therapies*
6. Request meets one of the following (a, b, or c):*
   a. As adjuvant: Dose does not exceed 3.6 mg/kg every 21 days for a maximum of 14 doses;
   b. For metastatic: Dose does not exceed 3.6 mg/kg every 21 days;
   c. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).
   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 6 months

B. Additional NCCN Recommended Uses (off-label) (must meet all)**:**

1. Diagnosis of one of the following (a or b):
   a. HER2-positive non-small cell lung cancer (NSCLC);
   b. Recurrent HER2-positive salivary gland tumor;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed as a single agent;

5. Request meets one of the following (a or b):*
   a. Dose does not exceed 3.6 mg/kg every 21 days;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 6 months

C. Other diagnoses/indications

1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, or documentation supports that member is currently receiving Kadcyla for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a, b, or c):*
   a. As adjuvant therapy for breast cancer: New dose does not exceed 3.6 mg/kg every 21 days for a maximum of 14 doses;
   b. For all other indications: New dose does not exceed 3.6 mg/kg every 21 days;
   c. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 policy – ERX.PA.01 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
HER2: human epidermal growth factor receptor 2 protein
NSCLC: non-small cell lung cancer

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): hepatotoxicity, cardiac toxicity embryo-fetal toxicity

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Breast cancer	*Adjuvant therapy for early breast cancer with residual disease* 3.6 mg/kg IV Q3WK (21-day cycle) for a total of 14 cycles unless there is disease recurrence or unmanageable toxicity. *Metastatic breast cancer* 3.6 mg/kg IV Q3WK (21-day cycle) until disease progression or unmanageable toxicity.	3.6 mg/kg

VI. Product Availability

Single-use vials: 100 mg, 160 mg

VII. References

1. Kadcyla Prescribing Information. South San Francisco, CA: Genentech, Inc.; February 2022. Available at: https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=BasicSearch.process. Accessed February 15, 2022.
2. Ado-trastuzumab emtansine. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed February 15, 2022.
3. Minckwitz GV, Huang CS, Mano MS, et al. Trastuzumab emtansine for residual invasive HER2-positive breast cancer. N Engl J Med 2019;380:617-28.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2018 annual review: age, specialist involvement in care, COC added; NCCN and FDA approved uses summarized for improved clarity; off-label NSCLC added; references updated.	02.13.18	05.18
2Q 2019 annual review: no significant changes; references reviewed and updated.	02.05.19	05.19
Criteria added for new FDA indication: adjuvant therapy in early breast cancer with residual disease; references reviewed and updated.	06.11.19	08.19
2Q 2020 annual review: no significant changes; references reviewed and updated.	02.18.20	05.20
2Q 2021 annual review: combined NSCLC and new off-label salivary gland tumor indications supported by NCCN into one off-label section under I.B.; references reviewed and updated.	02.05.21	05.21
2Q 2022 annual review: added criterion for single-agent therapy for off-label indications of NSCLC and salivary gland tumor per NCCN; references reviewed and updated.	02.15.22	05.22

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members.