

Medical Policy:

Phesgo™ (pertuzumab, trastuzumab and hyaluronidase-zzxf)

POLICY NUMBER	LAST REVIEW	ORIGIN DATE
MG.MM.PH.315	February 28, 2025	September 2, 2021

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The treating physician or primary care provider must submit to EmblemHealth, or ConnectiCare, as applicable (hereinafter jointly referred to as “EmblemHealth”), the clinical evidence that the member meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request preauthorization or post-payment review. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. Health care providers are expected to exercise their medical judgment in rendering appropriate care.

EmblemHealth established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary.

If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication.

EmblemHealth may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. EmblemHealth Services Company, LLC, has adopted this policy in providing management, administrative and other services to EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) related to health benefit plans offered by these entities. ConnectiCare, an EmblemHealth company, has also adopted this policy. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

Length of Authorization

Coverage will be provided for 6 months and may be renewed.

Dosing Limits [Medical Benefit]

Initial Dose:

- 1,200 mg pertuzumab, 600 mg trastuzumab, and 30,000 units hyaluronidase (15ml) subcutaneously over approximately 8 minutes

Maintenance Dose:

- 600 mg pertuzumab, 600 mg trastuzumab, and 20,000 units hyaluronidase (10ml) subcutaneously over approximately 5 minutes every 3 weeks

Guideline

I. INITIAL APPROVAL CRITERIA

Coverage is provided in the following conditions:

1. Patient is 18 years of age or older; **AND**
2. Baseline left ventricular ejection fraction (LVEF) is within normal limits; **AND**

3. Patient has human epidermal growth factor receptor 2 (HER2)-positive* disease; **AND**

1. Early Breast Cancer (EBC)

Phesgo will be used in combination with chemotherapy for one of the following (A or B):

- A. Use as neoadjuvant treatment:
 - i. Patient has locally advanced; inflammatory, or early-stage breast cancer (either greater than 2cm in diameter or node positive); **OR**
- B. Use as adjuvant treatment:
 - i. Patient has HER2-positive early breast cancer at high risk of recurrence

2. Metastatic Breast Cancer (MBC)

- A. Patient has not received prior anti-HER2 therapy or chemotherapy for metastatic disease; **AND**
- B. Will be used in combination with docetaxel

II. RENEWAL APPROVAL CRITERIA

Coverage can be renewed based on the following conditions:

- 1. Tumor response with stabilization of disease or decrease in size of tumor or tumor spread; **AND**
- 2. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: cardiotoxicity (i.e. left ventricular dysfunction, cardiomyopathy), infusion-related and hypersensitivity reactions, etc.

Limitations/Exclusions

Phesgo is not considered medically necessary for indications other than those listed above due to insufficient evidence of therapeutic value.

Applicable Procedure Codes

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

Applicable NDCs

Code	Description
50242-0260-01	Phesgo (600 mg pertuzumab / 600 mg trastuzumab / 20,000 units hyaluronidase-zzxf) in 10 ml vial
50242-0245-01	Phesgo (1200 mg pertuzumab / 600 mg trastuzumab / 30,000 units hyaluronidase-zzxf) in 15 ml vial

ICD-10 Diagnoses

Code	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 male breast
C50.022	Malignant neoplasm of nipple and areola, left male breast
C50.029	Malignant neoplasm of nipple and areola , unspecified male 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
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

Revision History

Company(ies)	DATE	REVISION
EmblemHealth & ConnectiCare	2/28/2025	Annual Review: no criteria changes
EmblemHealth & ConnectiCare	1/17/2024	Annual Review: no criteria changes
EmblemHealth & ConnectiCare	5/22/2023	Annual Review: no criteria changes
EmblemHealth & ConnectiCare	09/22/2022	Transferred policy to new template
EmblemHealth & ConnectiCare	7/7/2021	Updated procedure codes
EmblemHealth & ConnectiCare	1/1/2021	Updated J-code: J9316
EmblemHealth & ConnectiCare	9/2/2021	New Policy

References

1. Phesgo [package insert]. Genentech, Inc. South San Francisco, CA 9408; June 2020.
2. Pertuzumab, Trastuzumab, and Hyaluronidase. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. July 2020.
3. Pertuzumab/Trastuzumab/Hyaluronidase-zzxf. IBM Micromedex® DRUGDEX®. IBM Watson Health, Greenwood Village, Colorado, USA. July 2020.