Trastuzumab

NOTICE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

This policy informs prescribers of preferred products and provides an exception process for non-preferred products through prior authorization.

This program applies to the trastuzumab products specified in this policy. Coverage for a non-preferred product is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with the non-preferred product.

Table. Trastuzumab Products

Medication	Generic Name
Preferred Products:	
Herzuma	trastuzumab-pkrb
Kanjinti	trastuzumab-anns
Ogivri	trastuzumab-dkst
Ontruzant	trastuzumab-dttb
Trazimera	trastuzumab-qyyp
Targeted/Non-Preferred Products:	
Herceptin	trastuzumab
Herceptin Hylecta	trastuzumab and hyaluronidase-oysk

POLICY

EXCEPTION CRITERIA

Coverage for a non-preferred product is provided when the following criteria is met:

- The member has had a documented intolerable adverse event to at least three of the preferred products, and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information (i.e., known adverse reaction for both the reference product and biosimilar products).

Dosing and Administration
Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

- J9355 - Injection, trastuzumab (Herceptin), excludes biosimilar, 10 mg
- J9356 - Injection, trastuzumab, 10 mg and hyaluronidase-oysk

REFERENCES

- Herceptin [package insert]. South San Francisco, CA: Genetech, Inc; February 2021.
- Herceptin Hylecta [package insert]. South San Francisco, CA: Genentech, Inc.; February 2019.
- Kanjinti [package insert]. Thousand Oaks, CA: Amgen Inc; October 2019.
- Trazimera [package insert]. Cork, Ireland: Pfizer; November 2020.
- Herzuma [package insert]. Incheon, Republic of Korea: Celltrion, Inc; May 2019.
- Ogivri [package insert]. Morgantown, WV: Mylan Pharmaceuticals Inc.; February 2021.
- Ontruzant [package insert]. Incheon, Republic of Korea: Samsung Bioepis Co.; June 2021.

POLICY HISTORY

Policy #: 05.04.23
Original Effective Date: April 1, 2021
Reviewed: October 2022
Revised: October 2021
Current Effective Date: January 1, 2021