Clinical Policy: Ado-Trastuzumab Emtansine (Kadcyla)

Reference Number: CP.PHAR.229
Effective Date: 06.01.16
Last Review Date: 05.25
Line of Business: Commercial, HIM, Medicaid

Coding Implications
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.

It is the policy of health plans affiliated with Centene Corporation® that Kadycla 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. One of the following (a or b):
   a. Documentation of prior use of trastuzumab-based therapy and a taxane;
   b. Kadcyla prescribed as adjuvant treatment;
6. Request meets one of the following (a, b, or c):*
   a. As adjuvant treatment: Dose does not exceed 3.6 mg/kg every 21 days for a maximum of 14 doses;
   b. For metastatic treatment: 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:
Medicaid/HIM – 6 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Additional NCCN Recommended Uses (off-label) (must meet all)**:**
1. Diagnosis of one of the following (a or b):
   a. Recurrent, advanced, or metastatic 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:
Medicaid/HIM – 6 months
Commercial – 6 months or to the member's renewal date, whichever is longer

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit, 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 treatment 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:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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 – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, 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, and 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.; July 2024. Available at: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=23f3c1f4-0fc8-4804-a9e3-04cf25dd302e Accessed January 13,2025.
2. Ado-trastuzumab emtansine. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed January 27, 2025.
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.
4. National Comprehensive Cancer Network Guidelines. Breast Cancer Version 6.2024. Available at https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed January 27, 2025.

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
J9354	Injection, ado-trastuzumab emtansine, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2021 annual review: combined NSCLC and new off-label salivary gland tumor indications supported by NCCN into one off-label section	02.05.21	05.21

Reviews, Revisions, and Approvals	Date	P&T Approval Date
under I.B.; references for HIM line of business off-label use revised from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.		
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
Template changes applied to other diagnoses/indications.	10.07.22	
2Q 2023 annual review: no significant changes; clarified for NSCLC that disease is recurrent, advanced, or metastatic per NCCN; references reviewed and updated.	01.04.23	05.23
2Q 2024 annual review: no significant changes; references reviewed and updated.	01.18.24	05.24
2Q 2025 annual review: added bypass of prior use of trastuzumab-based therapy and a taxane if prescribed in the adjuvant setting per NCCN; references reviewed and updated.	01.13.25	05.25

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. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan

retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. 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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.