JOHNS HOPKINS MEDICINE / JOHNS HOPKINS HEALTHCARE	Johns Hopkins HealthCare LLC **Pharmacy Public** **Medical Management Drug Policies**	*Policy Number*	MMDP054
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	Subject **Perjeta**	*Revision Date*	04/20/2022
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This document applies to the following Participating Organizations:

US Family Health Plan

Keywords: Perjeta

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I. POLICY

A. Perjeta (pertuzumab) will require prior authorization for medical benefit coverage to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.

II. POLICY CRITERIA

A. Perjeta may be approved for patients who meet the following:
   1. Breast Cancer
      a. Documentation has been submitted showing Perjeta will be used in one of the following clinical situations:
         I. combination with trastuzumab and chemotherapy as pre-operative therapy for locally advanced, inflammatory, or early stage human epidermal growth factor receptor 2 (HER2)-positive breast cancer (either greater than 2 cm in diameter or node positive)
         II. combination with trastuzumab and chemotherapy as adjuvant therapy for HER2-positive breast cancer that is either node-positive or at high risk for recurrence
         III. combination with trastuzumab for the treatment of recurrent or metastatic HER2-positive breast cancer
   2. Colorectal Cancer
      a. Documentation has been submitted showing the following:
         I. Perjeta will be used in combination with trastuzumab for treatment of colorectal cancer with confirmed HER2-amplified and RAS and BRAF wild-type disease
            - Additionally documentation showing one of the following:
               - Patient is not appropriate for intensive therapy
               - Perjeta will be used as subsequent theapy for progression of advanced or metastatic disease
   3. Salivary Gland Tumor
      a. Documentation has been submitted showing Perjeta will be used in combination with trastuzumab for treatment of recurrent HER2-positive salivary gland tumors

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial approval will be limited to 12 months of therapy
B. Continuation of therapy may be approved in 12-month intervals with documentation showing the patient is continuing to tolerate the regimen and there has not been disease progression while on treatment
    1. Limitation: Adjuvant and neoadjuvant treatment of breast cancer will be approved for a total of 12 months of therapy.

IV. EXCLUSIONS

A. Perjeta will not be covered for the following:
    1. Any indications or uses that are not FDA-approved, or guideline-supported

V. RECOMMENDED DOSAGE

Please refer to the FDA-approved prescribing information for indication-specific dosing details.

VI. CODES

Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage.

Medication	HCPCS/CPT Code
Injection, pertuzumab, 1 mg	J9306

VII. REFERENCES

1. Perjeta [prescribing information]. South San Francisco, CA: Genentech, Inc.; February 2021.
2. The NCCN Drugs & Biologics Compendium® © 2022 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed March 4, 2022.

VIII. APPROVALS

Signature on file at JHHC

DATE OF REVISION	SUMMARY OF CHANGE
04/20/2022	Policy Creation

Review Dates: 04/20/2022

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