Draft Revision Policy: Do Not Implement

Trastuzumab and Hyaluronidase-oysk (Herceptin Hylecta™)

Requires Step Therapy *See* "Step Therapy Requirements for Provider Administered Specialty Medications" Document at: https://www.bcbst.com/docs/providers/Comm_BC_PAD_Step_Therapy_Guide.pdf

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

The proposal is to add text/statements in red and to delete text/statements with strikethrough:

POLICY

INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Herceptin Hylecta is indicated for adjuvant treatment of adults with HER2- overexpressing node positive or node negative (estrogen receptor [ER] / progesterone receptor [PR] negative or with one high risk feature) breast cancer:

- as part of a treatment regimen consisting of doxorubicin, cyclophosphamide, and either paclitaxel or docetaxel
- as part of a treatment regimen with docetaxel and carboplatin
- as a single agent following multi-modality anthracycline based therapy

Herceptin Hylecta is indicated in adults:

- in combination with paclitaxel for first-line treatment of HER2-overexpressing metastatic breast cancer
- as a single agent for treatment of HER2-overexpressing breast cancer in patients who have received one or more chemotherapy regimens for metastatic disease

Compendial Uses

HER2-positive breast cancer: may be substituted for intravenous trastuzumab and used as a single agent or in combination with other systemic therapies

All other indications are considered experimental/investigational and not medically necessary.

DOCUMENTATION

Submission of the following information ~~human epidermal growth factor receptor 2 (HER2) status~~ is necessary to initiate the prior authorization review: human epidermal growth factor receptor 2 (HER2) status

COVERAGE CRITERIA

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Breast Cancer

Authorization of up to 12 months may be granted for neoadjuvant treatment of HER2-positive breast cancer as part of a complete treatment regimen.

Authorization of up to 12 months may be granted for adjuvant treatment of HER2-positive breast cancer.

Authorization of 12 months may be granted for treatment of HER2-positive breast cancer with no response to preoperative systemic therapy, recurrent, advanced, unresectable, ~~advanced,~~ or metastatic (including brain metastases) disease.

Authorization of ~~up to~~ 12 months may be granted for treatment of HER2-negative metastatic breast cancer when used in combination with neratinib and fulvestrant as third-line or later therapy ~~neoadjuvant treatment of HER2-positive breast cancer as part of a complete treatment regimen.~~

CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed ~~outlined~~ in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen. Adjuvant and neoadjuvant treatment of breast cancer will be approved for a total of 12 months of therapy.

MEDICATION QUANTITY LIMITS

Drug Name	Diagnosis	Maximum Dosing Regimen
Herceptin Hylecta (Trastuzumab-Hyaluronidase-oysk)	Breast Cancer	Route of Administration: Subcutaneous 600/10,000mg-units every 3 weeks

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

1. Herceptin Hylecta [package insert]. South San Francisco, CA: Genentech, Inc.; June 2024.
2. The NCCN Drugs & Biologics Compendium® © 2025 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed September 8, 2025.
3. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Breast Cancer. Version 4.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed September 3, 2025.

BlueCross BlueShield of Tennessee

Policy

Medical Policy Manual

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EFFECTIVE DATE

ID_CHS_2025