Clinical Policy: Fam-Trastuzumab Deruxtecan-nxki (Enhertu)

Reference Number: CP.PHAR.456
Effective Date: 03.01.20
Last Review Date: 02.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Fam-trastuzumab deruxtecan-nxki (Enhertu®) is a human epidermal growth factor receptor 2 (HER2)-directed antibody and topoisomerase inhibitor conjugate.

FDA Approved Indication(s)

Enhertu is indicated for the treatment of adult patients:

- As neoadjuvant treatment of adult patients with HER2-positive (IHC 3+ or ISH+) Stage II or III breast cancer, as determined by an FDA-authorized test followed by a taxane, trastuzumab, and pertuzumab (THP).
- As adjuvant treatment of adult patients with HER2-positive (IHC 3+ or ISH+) breast cancer who have residual invasive disease following neoadjuvant trastuzumab (with or without pertuzumab) and taxane-based treatment.
- In combination with pertuzumab, for the first-line treatment of unresectable or metastatic HER2-positive (IHC 3+ or ISH+) breast cancer, as determined by an FDA-approved test.
- As monotherapy, for unresectable or metastatic HER2-positive (IHC 3+ or ISH+) breast cancer who have received a prior anti-HER2 based regimen either:
  - In the metastatic setting, or
  - In the neoadjuvant or adjuvant setting and have developed disease recurrence during or within six months of completing therapy.
- As monotherapy, for unresectable or metastatic hormone receptor (HR)-positive HER2-low (IHC 1+ or IHC 2+/ISH-) or HER2-ultralow (IHC 0 with membrane staining) breast cancer, as determined by an FDA-approved test, that has progressed on one or more endocrine therapies in the metastatic setting.
- As monotherapy, for unresectable or metastatic HER2-low (IHC 1+ or IHC 2+/ISH-) breast cancer, as determined by an FDA-approved test, who have received a prior chemotherapy in the metastatic setting or developed disease recurrence during or within 6 months of completing adjuvant chemotherapy.
- As monotherapy, for unresectable or metastatic non-small cell lung cancer (NSCLC) whose tumors have activating HER2 (ERBB2) mutations, as detected by an FDA-approved test, and who have received a prior systemic therapy*.
- As monotherapy, for locally advanced or metastatic HER2-positive (IHC 3+ or IHC 2+/ISH+) gastric or gastroesophageal junction (GEJ) adenocarcinoma who have received a prior trastuzumab-based regimen.
- As monotherapy, for unresectable or metastatic HER2-positive (IHC 3+) solid tumors who have received prior systemic treatment and have no satisfactory alternative treatment options.*

**This indication is approved under accelerated approval based on objective response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.*

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 Enhertu is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. IHC 3+ Solid Tumors (must meet all):

1. Diagnosis of HER2-positive, IHC 3+ solid tumor (*see Appendix D*);
2. Disease is unresectable or metastatic;
3. Prescribed by or in consultation with an oncologist;
4. Age ≥ 18 years;
5. Failure of at least one prior line of standard systemic regimen for the disease, or have no available standard treatment as a satisfactory alternative treatment option;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 5.4 mg/kg every 3 weeks;
   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 /ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Breast Cancer (must meet all)**:**

1. Diagnosis of breast cancer that is one of the following (a or b):
   a. Early stage and HER2-positive (IHC 3+ or ISH+);
   b. Recurrent, unresectable, or metastatic and any one of the following (i, ii, or iii):
      i. HER2-positive (IHC 3+ or ISH+);
      ii. HER2-low (IHC 1+ or IHC 2+/ISH-);
      iii. HER2-ultralow (IHC 0 with membrane staining);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a or b):
   a. For HER2-positive (IHC 3+ or ISH+) breast cancer, one of the following (i, ii, iii, iv, or v):
      i. Prescribed as neoadjuvant therapy for Stage II or III disease for 4 cycles, and provider attests that Enhertu will be followed by a taxane, trastuzumab, and pertuzumab;
      ii. Prescribed as adjuvant therapy for a member with residual invasive disease for 14 cycles following neoadjuvant trastuzumab (with or without pertuzumab) and taxane-based treatment;

iii. Prescribed in combination with pertuzumab as first-line therapy for unresectable or metastatic disease;
iv. Failure of one prior anti-HER2-based regimen (*see Appendix B*), unless contraindicated or clinically significant adverse effects are experienced;
v. Rapid disease progression within 6 months of neoadjuvant or adjuvant therapy (12 months for pertuzumab-containing regimens);

**Prior authorization may be required for anti-HER2-based regimens*

b. For HER2-low (IHC 1+ or IHC2+/ISH-) or ultralow (IHC 0 with membrane staining) breast cancer, one of the following (i, ii, or iii):
i. Failure of at least one prior line of chemotherapy, and member meets one of the following (1 or 2):
1) Member's cancer is HR-positive;
2) Member's cancer is HR-negative, and member does not have a germline BRCA 1/2 mutation;
ii. Disease recurrence during or within 6 months of completing adjuvant chemotherapy;
iii. If HR-positive, both of the following (1 and 2):
1) If request is for first-line therapy, member does not have a germline BRCA 1/2 mutation;
2) Failure of one prior endocrine therapy (*see Appendix B for examples*), unless contraindicated, clinically significant adverse effects are experienced, or member has visceral crisis;

5. Request meets one of the following (a or b):*
a. Dose does not exceed 5.4 mg/kg every 3 weeks;
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/ICHRA:

- As neoadjuvant therapy for early breast cancer – 12 weeks
- As adjuvant therapy for early breast cancer – 42 weeks
- All other breast cancer indications – 12 months

Commercial:

- As neoadjuvant therapy for early breast cancer – 12 weeks
- As adjuvant therapy for early breast cancer – 6 months
- All other breast cancer indications – 6 months or to the member's renewal date, whichever is longer

C. Gastric and Gastroesophageal Junction Cancer (must meet all)**:**
1. Diagnosis of HER2-positive gastric or GEJ adenocarcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is locally advanced, recurrent, or metastatic;
5. Failure of a trastuzumab-based regimen (*see Appendix B*);
6. Request meets one of the following (a or b):*
a. Dose does not exceed 6.4 mg/kg every 3 weeks;

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 /ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

D. Non-Small Cell Lung Cancer (must meet all)**:**

1. Diagnosis of recurrent, unresectable, or metastatic NSCLC;
2. Disease has activating HER2 (ERBB2) mutations;
3. Prescribed by or in consultation with an oncologist;
4. Age ≥ 18 years;
5. Failure of one prior line of chemotherapy (*see Appendix B for examples*);
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 5.4 mg/kg every 3 weeks;
   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/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

E. Colon or Rectal Cancer (off label) (must meet all):

1. Diagnosis of advanced or metastatic colon or rectal cancer, including appendiceal adenocarcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Member meets one of the following (a or b):
   a. Documentation supports failure of or presence of clinically significant adverse effects or contraindication to at least two FDA approved medications for the relevant diagnosis (e.g., oxaliplatin, irinotecan, FOLFOX [fluorouracil, leucovorin, and oxaliplatin] or CapeOX [capecitabine and oxaliplatin], bevacizumab);
   b. Enhertu is prescribed as adjuvant therapy for rectal cancer as a single agent for unresectable metachronous metastases (HER2-amplified and RAS and BRAF wild-type) (proficient mismatch repair/microsatellite-stable [pMMR/MSS] only) that converted to resectable disease after initial treatment;
5. Dose is within FDA maximum limit for any FDA-approved indication or 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/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

F. Other NCCN Recommended Uses (off-label) (must meet all)**:**

1. Diagnosis of one of the following (a, b, c, d, e, or f):

a. Recurrent or metastatic HER2-positive cervical cancer;
b. Recurrent HER2-positive salivary gland tumors;
c. Recurrent or metastatic HER2-positive endometrial carcinoma;
d. Recurrent HER2-positive ampullary adenocarcinoma;
e. Recurrent and locally advanced or metastatic HER2-positive pancreatic adenocarcinoma;
f. Recurrent or metastatic vaginal cancer;

2. Prescribed or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For cervical and vaginal cancer: Prescribed as a single agent following failure of ≥ 1 prior therapy (see *Appendix B*);
5. For salivary gland tumors: Prescribed as a single agent and member has one of the following (a or b):
   a. Distant metastases in patients with a performance status (PS) of 0-3;
   b. Unresectable locoregional recurrence or second primary with prior radiation therapy;
6. For endometrial carcinoma: Prescribed as a single agent following failure of ≥ 1 prior therapy (see *Appendix B*);
7. For ampullary adenocarcinoma: Prescribed as a single agent and the member has good performance status (ECOG 0-1 with good biliary drainage and adequate nutritional intake);
8. For pancreatic adenocarcinoma: prescribed as a single agent and the member has one of the following (a or b):
   a. Good performance status (ECOG PS 0-1, with good biliary drainage and adequate nutritional intake);
   b. Intermediate performance status (ECOG 2);
9. Dose is within FDA maximum limit for any FDA-approved indication or 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/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

G. 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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, 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 Enhertu 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. For breast cancer, NSCLC, or IHC 3+ solid cancers: New dose does not exceed 5.4 mg/kg every 3 weeks and one of the following (i or ii):
      i. If neoadjuvant therapy for early breast cancer: maximum of 4 cycles;
      ii. If adjuvant therapy for early breast cancer: maximum of 14 cycles;
   b. For gastric or GEJ adenocarcinoma: New dose does not exceed 6.4 mg/kg every 3 weeks;
   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/ICHRA:

- As neoadjuvant therapy for early breast cancer – up to a total of 12 weeks of Enhertu therapy
- As adjuvant therapy for early breast cancer – up to a total of 42 weeks of Enhertu therapy
- All other indications – 12 months

Commercial:

- As neoadjuvant therapy for early breast cancer – up to a total of 12 weeks of Enhertu therapy
- As adjuvant therapy for early breast cancer – 6 months or up to a total of 42 weeks of Enhertu therapy, whichever comes first
- All other indications – 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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, 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 policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

dMMR: mismatch repair deficient
FDA: Food and Drug Administration
GEJ: gastroesophageal junction
HER2: human epidermal growth factor receptor 2
HR: hormone-receptor
IHC: immunohistochemistry (assay)
MSI-H: microsatellite instability-high
NCCN: National Comprehensive Center Network
NSCLC: non-small cell lung cancer
PD-L1: programmed death ligand-1
THP: taxane, trastuzumab, and pertuzumab
TMB: tumor mutational burden

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
HER2+ Breast Cancer NCCN examples of systemic therapies for recurrent or metastatic disease: • Aromatase inhibitor ± trastuzumab • Aromatase inhibitor ± lapatinib • Pertuzumab + trastuzumab + docetaxel	Varies	Varies
Breast Cancer • Examples of systemic therapies include but are not limited to: eribulin, capecitabine, gemcitabine, nab-paclitaxel, paclitaxel	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
• Examples of endocrine therapies for HR+ disease include but are not limited to: sacituzumab, palbocicib, ribociclib, abemacicilib, tamoxifen, letrozole, anastrozole, exemestane		
Gastric and Gastroesophageal Junction Cancer trastuzumab-based regimen	8 mg/kg IV followed by 6 mg/kg IV q 3 weeks	8 mg/kg
NSCLC Examples of systemic therapies include but are not limited to: • Carboplatin or cisplatin + pemetrexed + pembrolizumab • Carboplatin + paclitaxel + bevacizumab + atezolizumab • Carboplatin + albumin-bound paclitaxel + atezolizumab • Carboplatin + paclitaxel or albumin-bound paclitaxel + pembrolizumab • Nivolumab + ipilimumab + paclitaxel + carboplatin or cisplatin Examples of targeted therapies include but are not limited to: • EGFR mutation positive: afatinib, erlotinib, dacomitinib, gefitinib, osimertinib, erlotinib + ramucirumab, erlotinib + bevacizumab (non-squamous) • BRAF: dabrafenib/trametinib, dabrafenib, vemurafenib • ALK: alectinib, brigatinib, ceritinib, crizotinib, lorlatinib ROS1: ceritinib, crizotinib, entrectinib	Varies	Varies
Cervical Cancer Examples of first-line therapies include but are not limited to: • Cisplatin or carboplatin + paclitaxel ± bevacizumab • Topotecan + paclitaxel ± bevacizumab • Cisplatin + topotecan • Cisplatin • Carboplatin	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Examples of NCCN-preferred second-line or subsequent therapies include but are not limited to: • Tisotumab vedotin-tftv • Cemiplimab • Bevacizumab • Paclitaxel • Albumin-bound paclitaxel • Docetaxel • Fluorouracil • Gemcitabine • Pemetrexed • Topotecan • Vinorelbine • Irinotecan		
Endometrial Carcinoma Examples of first-line therapies include but are not limited to: • Carboplatin + paclitaxel + trastuzumab • Carboplatin + docetaxel • Carboplatin + paclitaxel + bevacizumab Examples of NCCN-preferred second-line or subsequent therapies include but are not limited to: • Cisplatin + doxorubicin • Cisplatin + doxorubicin + paclitaxel • Cisplatin • Carboplatin • Doxorubicin • Liposomal doxorubicin • Paclitaxel • Albumin-bound paclitaxel • Topotecan • Bevacizumab • Temsirolimus • Cabozantinib • Docetaxel • Ifosfamide (for carcinosarcoma) • Ifosfamide + paclitaxel (for carcinosarcoma) • Cisplatin + ifosfamide	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose

Vaginal Cancer
Examples of first-line therapies for recurrent or metastatic disease include but are not limited to:
• For PD-L1-positive tumors:
  ○ Cisplatin/paclitaxel + pembrolizumab +/- bevacizumab
  ○ Carboplatin/paclitaxel + pembrolizumab +/- bevacizumab
• Cisplatin/paclitaxel + bevacizumab
• Carboplatin/paclitaxel + bevacizumab
 	
Examples of NCCN-preferred second-line or subsequent therapies include but are not limited to:
• For tumor microburden (TMB)-high, PD-L1-positive, or microsatellite instability-high (MSI-H)/mismatch repair deficient (dMMR) tumors: pembrolizumab
• Other recommended:
  ○ Bevacizumab
  ○ Paclitaxel
  ○ Albumin-bound paclitaxel
  ○ Docetaxel
  ○ Fluorouracil
  ○ Gemcitabine
  ○ Pemetrexed
  ○ Topotecan
  ○ Vinorelbine
  ○ Irinotecan
  ○ Tisotumab vedotin-tftv
  ○ Cemiplimab
  ○ Ipilimumab + nivolumab
	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): interstitial lung disease and pneumonitis; embryo-fetal toxicity

Appendix D: IHC 3+ Solid Tumors

- In DESTINY-PanTumor02, DESTINY-Lung01, and DESTINY-CRC02 clinical trials, the following were solid tumor types that were included in the study: colorectal cancer, bladder cancer, biliary tract cancer, NSCLC, endometrial cancer, ovarian cancer, cervical cancer, salivary gland cancer, pancreatic cancer, oropharyngeal neoplasm, vulvar cancer,

extramammary Paget's disease, lacrimal gland cancer, lip and/or oral cavity cancer, esophageal adenocarcinoma, and esophageal squamous cell carcinoma.

- NCCN guidelines also support the use of Enhertu as a single agent for second-line and subsequent therapy for the following solid tumor types that are IHC 3+: recurrent appendiceal adenocarcinoma or Goblet cell adenocarcinoma.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Early breast cancer	Neoadjuvant therapy: 5.4 mg/kg IV every 3 weeks for 4 cycles, followed by THP regimen for 4 cycles Adjuvant therapy: 5.4 mg/kg IV every 3 weeks for 14 cycles unless disease recurrence or unacceptable toxicity	5.4 mg/kg Neoadjuvant therapy: 4 cycles of Enhertu therapy (12 weeks) Adjuvant therapy: up to 14 cycles of Enhertu therapy (up to 42 weeks)
Metastatic breast cancer, NSCLC, IHC 3+ solid tumors	5.4 mg/kg IV every 3 weeks	5.4 mg/kg
Gastric, GEJ cancer	6.4 mg/kg IV every 3 weeks	6.4 mg/kg

VI. Product Availability

Single-dose vial: 100 mg lyophilized powder

VII. References

1. Enhertu Prescribing Information. Basking Ridge, NJ: Daiichi Sankyo, Inc.; May 2026. Available at: www.enhertu.com. Accessed June 5, 2026.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at http://www.nccn.org/professionals/drug_compendium. Accessed June 5, 2026.
3. National Comprehensive Cancer Network Guidelines. Breast Cancer Version 3.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed June 5, 2026.
4. Modi S, Saura C, Yamashita T, et al. Trastuzumab deruxtecan in previously treated HER2-positive breast cancer. *N Engl J Med*. 2019; doi: 10.1056/NEJMoa1914510.

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
J9358	Injection, fam-trastuzumab deruxtecan-nxki, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: no significant changes; references reviewed and updated.	09.13.21	02.22
RT4: added criteria for new FDA-approved indication as 2nd line for breast cancer per PI; added criteria for 1st-line therapy for breast cancer in select patients per NCCN; references reviewed and updated.	05.18.22	
RT4: added criteria for new FDA-approved indications for NSCLC and HER2-low breast cancer, references reviewed and updated. Template changes applied to other diagnoses/indications.	08.30.22	
1Q 2023 annual review: added off-label use for advanced or metastatic colon and rectal cancers per NCCN; for NSCLC removed the criterion to require treatment of non-HER2 mutations first, to align with NCCN recommendations; added recurrent gastric or GEJ cancer as a covered indication per NCCN; RT4: added language to the FDA Approved Indications section re: using an FDA-approved test to identify HER2-low breast cancer; references reviewed and updated.	11.15.22	02.23
1Q 2024 annual review: no significant changes; per NCCN guidelines, clarified that off-label use for appendiceal adenocarcinoma is included as a colorectal cancer, added criteria for use as adjuvant therapy in rectal cancer, added criteria for off-label use for cervical cancer, salivary gland tumors, and endometrial carcinoma; references reviewed and updated.	11.28.23	02.24
RT4: added newly approved indication for IHC 3+ solid tumors.	05.31.24	
1Q 2025 annual review: per NCCN guidelines for HER2-low breast cancer added a bypass of prior endocrine therapy for HR-positive disease if the member has visceral crisis; references reviewed and updated.	12.02.24	02.25
1Q 2026 annual review: added NCCN-supported uses for recurrent NSCLC (in addition to unresectable or metastatic), ampullary adenocarcinoma, pancreatic adenocarcinoma, and vaginal cancer; per NCCN recs added a requirement for BRCA 1/2 negativity if using Enhertu for HR-negative breast cancer as second-line or later therapy; updated initial auth durations from 6 months to 12 months for Medicaid/HIM; references reviewed and updated. RT4: added newly approved indication for HR-positive, HER2-low or HER2-ultralow breast cancer. RT4: added newly approved indication for use in combination with pertuzumab as first-line therapy for HER2-positive breast cancer.	12.29.25	02.26
RT4: added two newly approved indications for use as adjuvant and neoadjuvant therapy in early breast cancer; added ICHRA line of business; references reviewed and updated.	06.05.26	

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.