Clinical Policy: Pertuzumab (Perjeta), Pertuzumab-dpzb (Poherdy)

Reference Number: CP.PHAR.227
Effective Date: 06.01.16
Last Review Date: 05.26
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

Pertuzumab (Perjeta®) and its biosimilar, pertuzumab-dpzb (Poherdy®), are human epidermal growth factor receptor 2 protein (HER2)/neu receptor antagonists.

FDA Approved Indication(s)

Perjeta and Poherdy are indicated for:

- Use in combination with trastuzumab and docetaxel for the treatment of patients with HER2-positive metastatic breast cancer (MBC) who have not received prior anti-HER2 therapy or chemotherapy for metastatic disease.
- Use in combination with trastuzumab and chemotherapy as:
  - Neoadjuvant treatment of patients with HER2-positive, locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive) as part of a complete treatment regimen for early breast cancer;
  - Adjuvant treatment of patients with HER2-positive early breast cancer at high risk of recurrence.

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 Perjeta and Poherdy are **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. One of the following (a or b):
   a. Prescribed in combination with Enhertu®* for the treatment of unresectable or metastatic breast cancer;
   b. Prescribed in combination with trastuzumab* and one of the following (i, ii, iii, or iv):
      i. With taxane-containing chemotherapy (e.g., docetaxel or paclitaxel) for the treatment of unresectable or metastatic breast cancer;
      ii. With chemotherapy as neoadjuvant or adjuvant treatment (*see Appendix B*);

iii. Member was previously treated with chemotherapy and trastuzumab in absence of Perjeta/Poherdy;
iv. With aromatase inhibitor (e.g., anastrozole, exemestane, letrozole) for postmenopausal women or premenopausal women treated with ovarian ablation/suppression;

**Prior authorization may be required*

5. Request meets one of the following (a or b):*
   a. Initial dose: 840 mg, followed by maintenance dose: 420 mg 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. Additional NCCN Recommended Uses (off-label) (must meet all):
1. Diagnosis of one of the following (a, b, c, or d):
   a. Brain metastases in breast cancer;
   b. Recurrent salivary gland tumor;
   c. Unresectable, or resected gross residual (R2) disease, or metastatic gallbladder cancer or cholangiocarcinoma;
   d. Colorectal cancer, small bowel adenocarcinoma, appendiceal neoplasms and cancer and disease is both of the following (i, and ii):
      i. Wild-type *RAS* (defined as wild-type in both KRAS and NRAS [i.e., KRAS and NRAS mutation-negative] as determined by an FDA-approved test for this use);
      ii. Wild-type *BRAF* (i.e., BRAF mutation-negative);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is HER2-positive;
5. Prescribed in combination with trastuzumab;*

   **Prior authorization may be required.*
6. 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

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/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 Perjeta/Poherdy 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 neoadjuvant or adjuvant breast cancer treatment, maximum duration does not exceed a total of 1 year treatment (up to 18 cycles);
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 420 mg every 3 weeks;
   b. 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 – 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/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

BRAF: v-raf murine sarcoma viral oncogene homolog B1
FDA: Food and Drug Administration
HER2: human epidermal growth factor receptor 2
KRAS: Kirsten rat sarcoma 2 viral oncogene homologue
MBC: metastatic breast cancer
NRAS: neuroblastoma RAS viral oncogene homologue

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
Examples of drugs that may be used with Perjeta/Poherdy for breast cancer: • Chemotherapeutic agents: carboplatin, cyclophosphamide, doxorubicin, docetaxel, paclitaxel • HER2-targeted agents: trastuzumab (Herceptin®, Kadcyla), lapatinib (Tykerb), Nerlynx® (neratinib) • Endocrine therapy: tamoxifen; aromatase inhibitors: anastrozole (Arimidex®), letrozole (Femara®), exemestane (Aromasin®).	Regimens are dependent on a variety of factors including menopausal status, treatment/progression history, clinical stage, histology, mutational and receptor status, treatment purpose (e.g., adjuvant and neoadjuvant treatment, treatment for metastatic disease).	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): known hypersensitivity to pertuzumab products or to any of its excipients
- Boxed warning(s): left ventricular dysfunction, embryo-fetal toxicity

Appendix D: General Information

Residual Tumor (R) Classification:		
R0	no residual tumor	resected, negative margin
R1	microscopic residual tumor	resected, positive margin

Residual Tumor (R) Classification:		
R2	macroscopic residual tumor	resected, gross residual disease

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Breast cancer	Initial dose of 840 mg IV, followed by maintenance dose of 420 mg IV every 3 weeks *For metastatic disease,* Perjeta/Poherdy should be administered as outlined above. *For neoadjuvant treatment*, Perjeta/Poherdy should be administered for 3-6 cycles. Following surgery, patients should continue to receive Perjeta/Poherdy to complete 1 year of treatment (up to 18 cycles) *For adjuvant treatment*, Perjeta/Poherdy should be administered for a total of 1 year (up to 18 cycles) or until disease recurrence or unmanageable toxicity.	See regimens

VI. Product Availability

Single-dose vial for injection: 420 mg/14 mL

VII. References

1. Perjeta Prescribing Information. South San Francisco, CA: Genentech, Inc.; June 2025 Available at: https://www.gene.com/download/pdf/perjeta_prescribing.pdf. Accessed January 23, 2026.
2. Poherdy Prescribing Information. Jersey City, NJ: Organon LLC; November 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761450s000lbl.pdf. Accessed January 23, 2026.
3. Pertuzumab. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed January 30, 2026.
4. Pertuzumab-dpzb. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed February 11, 2026.
5. National Comprehensive Cancer Network Guidelines. Breast Cancer Version 1.2026. Available at https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed January 30, 2026.
6. Hermanek P and Wittekind C. Residual tumor (R) classification and prognosis. Semin Surg Oncol. 1994 Jan-Feb;10(1):12-20

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
J9306	Injection, pertuzumab, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2022 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	02.15.22	05.22
Revised criteria to clarify pertuzumab must be prescribed with trastuzumab and docetaxel or chemotherapy per request from PA Ops. Template changes applied to other diagnoses/indications.	09.06.22	
2Q 2023 annual review: for breast cancer, added option for Perjeta without taxanes and chemotherapy for members previously treated with chemotherapy and trastuzumab without pertuzumab and revised docetaxel to taxane-containing chemotherapy per NCCN 2A recommendation; for colorectal cancer, removed requirement for no previous use of a HER2 inhibitor therapy; added unresectable or metastatic HER2-positive gallbladder cancer and cholangiocarcinoma to NCCN recommended uses (off-label); references reviewed and updated.	01.05.23	05.23
2Q 2024 annual review: for gallbladder cancer and cholangiocarcinoma, added option for treatment with resected gross residual (R2) disease; residual (R) tumor classification added to Appendix D; references reviewed and updated.	01.18.24	05.24
2Q 2025 annual review: for continued therapy, added criterion for maximum duration for neoadjuvant or adjuvant breast cancer treatment, does not exceed a total of 1 year treatment (up to 18 cycles) per PI; updated standard approval language for commercial line of business to continued therapy of "6 months or to the member's renewal date, whichever is longer;" references reviewed and updated.	01.13.25	05.25
RT4: added newly approved biosimilar, Poherdy.	11.19.25	
2Q 2026 annual review: for breast cancer, added option to be prescribed in combination with Enhertu and added option for use of aromatase inhibitor with trastuzumab for postmenopausal or premenopausal receiving ovarian ablation or suppression; added off-label indication for brain metastases in breast cancer; small bowel adenocarcinoma, appendiceal neoplasms and cancers per NCCN; for all indications for Medicaid and HIM, extended initial approval duration from 6 to 12 months; references reviewed and updated. Added ICHRA line of business.	03.30.26	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.

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.