Mass General Brigham
Health Plan

Herceptin (trastuzumab)
Herceptin Hylecta(trastuzumab-hyluronidase-oysk)
Hercessi (trastuzumab-strf)
Herzuma (trastuzumab-pkrb)
Ontruzant (trastuzumab-dttb)
Trazimera (trastuzumab-qyyp)
Effective 05/01/2025

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview
Trastuzumab is a monoclonal antibody which binds to the extracellular domain of the human epidermal growth factor receptor 2 protein (HER-2); it mediates antibody-dependent cellular cytotoxicity by inhibiting proliferation of cells which overexpress HER-2 protein.

No PA required	PA required
Ogivri	Herceptin
Kanjinti	Ontruzant
	Trazimera
	Herceptin Hylecta
	Herzuma
	Hercessi

Coverage Guidelines
Authorization may be reviewed for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted for members when ALL the following criteria are met:
1. The member has ONE of the following diagnoses:
    a. HER2-overexpressing breast cancer
    b. HER2-overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma
2. The member meets ONE of the following

a. The member has had adverse effect or intolerance attributed to the active ingredient of at least one of the following: Ogivri and Kanjinti
b. Documentation that the member has a contraindication attributed to Ogivri and Kanjinti

Continuation of Therapy

Requests for reauthorization will be approved when the following criteria are met:

1. Documentation of improvement of member's condition.

Limitations

1. Initial approvals and reauthorizations will be granted for 12 months.

References

1. Herceptin (trastuzumab) [prescribing information]. South San Francisco, CA: Genentech, Inc.; June 2024.
2. Kanjinti (trastuzumab-anns) [prescribing information]. Thousand Oaks, CA: Amgen, Inc.; October 2022.
3. Ogivri (trastuzumab-dkst) [prescribing information]. Morgantown, WV: Mylan Pharmaceuticals Inc.; February 2021.
4. Trazimera (trastuzumab-qyyp) [prescribing information]. New York, NY: Pfizer Labs; November 2020.
5. Herzuma (trastuzumab-pkrb) [prescribing information]. North Wales, PA: Teva Pharmaceuticals USA Inc; November 2024.

Review History

11/18/2020 – Created for Comm/Exch preferred strategy. Effective 1/1/20
11/17/2021 – Updated and Reviewed for Nov P&T; Effective 1/1/2022.
02/12/2025 – Reviewed and Updated for February P&T. Added Hercessi to the policy and clarified preferred product step requirements. Effective 05/01/2025.