Clinical Policy: Margetuximab-cmkb (Margenza)

Reference Number: ERX.SPA.425
Effective Date: 03.01.21
Last Review Date: 02.22
Line of Business: Commercial, Medicaid

Revision Log

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

Description
Margetuximab-cmkb (Margenza™) is a human epidermal growth factor receptor 2 (HER2)/neu receptor antagonist.

FDA Approved Indication(s)
Margenza is indicated, in combination with chemotherapy, for the treatment of adult patients with metastatic HER2-positive breast cancer who have received two or more prior anti-HER2 regimens, at least one of which was for metastatic disease.

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.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Margenza is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of metastatic HER2-positive breast cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Failure of two anti-HER2-based regimens (*see Appendix B*), at least one of which was for metastatic disease, unless contraindicated or clinically significant adverse effects are experienced;
   **Prior authorization may be required for anti-HER2-based regimens*
5. Prescribed in combination with chemotherapy (e.g., capecitabine, eribulin, gemcitabine, vinorelbine);
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 15 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: 6 months

B. Other diagnoses/indications

1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

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

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or documentation supports that member is currently receiving Margenza 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 or b):*
   a. New dose does not exceed 15 mg/kg every 3 weeks;
   b. New dose is supported by practice guideline 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: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 policy – ERX.PA.01 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
HER2: human epidermal growth factor receptor 2

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Herceptin® (trastuzumab) ± any of the following: • Aromatase inhibitor • Aromatase inhibitor ± Tykerb® (lapatinib) • Fulvestrant (Faslodex®) • Tamoxifen	Varies	Varies
Aromatase inhibitor ± Tykerb (lapatinib)		
Perjeta® (pertuzumab) + Herceptin (trastuzumab) + either of the following: • Docetaxel • Paclitaxel		
Kadcyla® (ado-trastuzumab emtansine)	3.6 mg/kg IV every 3 weeks (21-day cycle)	3.6 mg/kg
Herceptin (trastuzumab) + any of the following: • Paclitaxel ± carboplatin • Docetaxel • Vinorelbine • Xeloda® (capecitabine) • Tykerb (lapatinib)	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Tykerb (lapatinib) + Xeloda (capecitabine)	Tykerb 1,250 mg PO QD days 1-21 + Xeloda 1,000 mg/m^2 PO BID days 1-14 (21-day cycle)	Tykerb 1,250 mg/day Xeloda 2,000 mg/m^2/day

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): left ventricular dysfunction; embryo-fetal toxicity

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Breast cancer	15 mg/kg IV every 3 weeks	15 mg/kg

VI. Product Availability

Single-dose vial: 250 mg/10 mL

VII. References

1. Margenza Prescribing Information. Rockville, MD: MacroGenics, Inc.; December 2020. Available at: www.margenza.com. Accessed November 20, 2021.
2. National Comprehensive Cancer Network. Breast Cancer Version 8.2021. Available at: http://www.nccn.org/professionals/physician_gls/pdf/breast.pdf. Accessed November 20, 2021.
3. DRUGDEX® System [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed November 20, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.07.21	02.21
1Q 2022 annual review: added requirement for use in combination with chemotherapy per FDA label and NCCN recommendations; references reviewed and updated.	11.20.21	02.22

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.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.