PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Tukysa Prior Authorization Policy
- Tukysa® (tucatinib tablets –Seagan)

REVIEW DATE: 05/07/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Tukysa, a kinase inhibitor, is indicated for the following uses in adults:[1]

- **Breast cancer**, in combination with trastuzumab and capecitabine, for the treatment of advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-positive disease, including patients with brain metastases, who have received one or more prior anti-HER2-based regimens in the metastatic setting.
- **Colorectal cancer**, in combination with trastuzumab, for the treatment of RAS wild-type HER2-positive unresectable or metastatic disease that has progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy.
  This indication is approved under accelerated approval based on tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

Guidelines

Tukysa is discussed in the guidelines from the National Comprehensive Cancer Network (NCCN):

- **Biliary Tract Cancers**: NCCN guidelines (version 1.2025 – March 20, 2025) recommend Tukysa + trastuzumab for HER2-positive tumors as "useful in certain circumstances" as subsequent line therapy for unresectable and metastatic disease if there is disease progression.[2]
- **Breast Cancer:** NCCN guidelines (version 4.2025 – April 17, 2025) recommend Tukysa + trastuzumab + capecitabine in the third-line and beyond setting as a "preferred" regimen (category 1) for the treatment of recurrent unresectable (local or regional) or Stage IV HER2-positive disease in patients with both systemic and central nervous system (CNS) progression.[3] There is a footnote that states it may be given in the second-line setting (category 2A). Perjeta® (pertuzumab intravenous infusion) + trastuzumab + docetaxel (category 1) and Perjeta + trastuzumab + paclitaxel (category 2A) are "preferred" first-line regimens. Enhertu® (fam-trastuzumab deruxtecan-nxki intravenous infusion) [category 1] is a "preferred" second-line agent. NCCN central nervous system guidelines (version 5.2024 – March 18, 2025) recommend Tukysa + capecitabine + trastuzumab as "preferred" treatment for brain metastases in HER2-positive breast cancer if previously treated with one or more anti-HER2-based regimens (category 1).[4]
- **Colon Cancer and Rectal Cancer:** NCCN colon cancer guidelines (version 3.2025 – April 24, 2025) and NCCN rectal cancer guidelines (version 2.2025 – March 31, 2025) recommend Tukysa in combination with trastuzumab as a primary or subsequent treatment option for advanced or metastatic HER2-amplified, *RAS* and *BRAF* wild type disease (category 2A) in a variety of different clinical scenarios.[5,6]

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Tukysa. All approvals are provided for the duration noted below.

- **Tukysa® (tucatinib tablets -Seagan)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indications

1. **Breast Cancer.** Approve for 1 year if the patient meets ALL of the following (A, B, C, D, and E):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has recurrent or metastatic breast cancer; AND
   C) Patient has human epidermal growth factor receptor 2 (HER2)-positive disease; AND

D) Patient has received at least one prior anti-HER2-based regimen in the metastatic setting; AND
Note: Examples of anti-HER2-based regimens include Perjeta (pertuzumab intravenous infusion) + trastuzumab + docetaxel, Perjeta + trastuzumab + paclitaxel; Kadcyla (ado-trastuzumab emtansine intravenous infusion), capecitabine + trastuzumab or lapatinib tablets, trastuzumab + lapatinib tablets, Enhertu (fam-trastuzumab deruxtecan-nxki intravenous infusion), trastuzumab + docetaxel or vinorelbine, Nerlynx (neratinib tablets) + capecitabine, and Margenza (margetuximab-cmkb intravenous infusion) + chemotherapy (capecitabine, Halaven [eribulin intravenous infusion], gemcitabine, or vinorelbine).

E) The medication is used in combination with trastuzumab and capecitabine.

2. **Colon or Rectal Cancer**. Approve for 1 year if the patient meets ALL of the following (A, B, C, D, and E):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has unresectable or metastatic disease; AND
   C) Patient has human epidermal growth factor receptor 2 (HER2)-amplified disease; AND
   D) Patient's tumor or metastases are wild-type *RAS* (*KRAS* wild-type and *NRAS* wild-type); AND
   E) The medication is used in combination with trastuzumab.

Other Uses With Supportive Evidence

3. **Biliary Tract Cancer**. Approve for 1 year if the patient meets ALL of the following (A, B, C, D, and E):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has unresectable or metastatic disease; AND
   C) Patient has human epidermal growth factor receptor 2 (HER2)-positive disease; AND
   D) Patient has tried at least one systemic regimen; AND
   Note: Examples of a systemic regimen include one or more of the following medications: Imfinzi (durvalumab intravenous infusion), gemcitabine, cisplatin, Keytruda (pembrolizumab intravenous infusion), capecitabine, oxaliplatin, albumin-bound paclitaxel.
   E) The medication is used in combination with trastuzumab.

CONDITIONS NOT COVERED

- **Tukysa® (tucatinib tablets - Seagan)**

is(are) considered not medically necessary for ANY other use(s).

REFERENCES

1. Tukysa® tablets [prescribing information]. Bothell, WA: Seagen; January 2023.
2. The NCCN Biliary Tract Cancers Clinical Practice Guidelines in Oncology (version 1.2025 – March 20, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on May 2, 2025.

3. The NCCN Breast Cancer Clinical Practice Guidelines in Oncology (version 4.2025 – April 17, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on May 2, 2025.
4. The NCCN Central Nervous System Clinical Practice Guidelines in Oncology (version 5.2024 – March 18, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on May 2, 2025.
5. The NCCN Colon Cancer Clinical Practice Guidelines in Oncology (version 3.2025 – April 24, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on May 2, 2025.
6. The NCCN Rectal Cancer Clinical Practice Guidelines in Oncology (version 2.2025 – March 31, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on May 2, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Colon and Rectal Cancer:** The requirement that the patient has human epidermal growth factor receptor 2 (HER2)-positive disease was reworded to "HER2-amplified disease." The requirements that the patient has previously been treated with a fluoropyrimidine with a note of examples of fluoropyrimidine; oxaliplatin; and irinotecan were removed.	06/07/2023
Annual Revision	**Colon or Rectal Cancer:** The indication "Colon and Rectal Cancer" was reworded to "Colon or Rectal Cancer." **Biliary Tract Cancer:** Indication and criteria were added to Other Uses with Supportive Evidence.	05/15/2024
Annual Revision	No criteria changes.	05/07/2025