PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Oral – HER2 Inhibitor) – Hernexeos Prior Authorization Policy
- Hernexeos® (zongertinib tablets –Boehringer Ingelheim)

REVIEW DATE: 08/13/2025

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

Hernexeos, a kinase inhibitor, is indicated for the treatment of unresectable or metastatic non-squamous **non-small cell lung cancer (NSCLC)** in tumors that have human epidermal growth factor receptor 2 (HER2) [ErbB-2 receptor tyrosine kinase 2 {ERBB2}] tyrosine kinase domain activating mutations, as detected by an FDA-approved test, in adults who have received prior systemic therapy.[1]

Guidelines

The NCCN NSCLC guidelines (version 8.2025 – August 15, 2025) recommend Hernexeos or Enhertu® (fam-trastuzumab deruxtecan-nxki intravenous infusion) as the "Preferred" subsequent therapy options (both category 2A) for *ERBB2* (*HER2*) mutation-positive disease.[2] Kadcyla® (ado-trastuzumab emtansine intravenous infusion) is recommended as an "Other Recommended" subsequent therapy option (category 2A). Upon subsequent therapy progression, any of the three HER2-

directed therapies (Hernexeos, Enhertu, or Kadcyla) can be used, if not received previously. Enhertu and Kadcyla are HER2-targeted antibody-drug-conjugates. The "Preferred" first-line regimens for adenocarcinoma are the following for NSCLC with *HER2* (*ERBB2*) mutations: Keytruda (pembrolizumab intravenous infusion) + carboplatin + pemtrexed; Keytruda + cisplatin + pemetrexed; and Libtayo (cemiplimab-rwlc intravenous infusion) + pemetrexed + carbo- or cisplatin (all category 1).

POLICY STATEMENT

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

Hernexeos® (zongertinib tablets - Boehringer Ingelheim) 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 Indication

1. **Non-Small Cell Lung 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 non-squamous disease; AND
   - **C)** Patient has human epidermal growth factor receptor 2 (HER2) [ERBB2] activating mutation; AND
   - **D)** The mutation was detected by an approved test; AND
   - **E)** Patient has received at least one prior systemic therapy.
     Note: Examples include checkpoint inhibitors such as Keytruda® (pembrolizumab intravenous infusion), Libtayo® (cemiplimab-rwlc intravenous infusion), Tecentriq® (atezolizumab intravenous infusion), Opdivo® (nivolumab intravenous infusion), or Imjudo® (tremelimumab-actl intravenous infusion) in combination with chemotherapy (e.g., carboplatin, cisplatin, pemetrexed, paclitaxel, albumin-bound paclitaxel, bevacizumab), chemotherapy alone (e.g., docetaxel, gemcitabine, etoposide, vinorelbine, other chemotherapy noted above).

CONDITIONS NOT COVERED

Hernexeos® (zongertinib tablets - Boehringer Ingelheim) is(are) considered not medically necessary for ANY other use(s). Criteria will be updated as new published data are available.

REFERENCES

1. Hernexeos® tablets [prescribing information]. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals; August 2025.
2. The NCCN Non-Small Cell Lung Cancer Clinical Practice Guidelines in Oncology (version 8.2025 – August 15, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on August 21, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	08/13/2025
Update	08/21/2025: Updated overview with new guideline information.	--