Reference number
1854-A

SPECIALTY GUIDELINE MANAGEMENT

COMETRIQ (cabozantinib)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indication
Treatment of progressive, metastatic medullary thyroid cancer (MTC).

B. Compendial Uses
1. Follicular, Hurthle cell, and papillary thyroid carcinoma
2. Non-small cell lung cancer with RET gene arrangements

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

A. Thyroid carcinoma
Authorization of 12 months may be granted for the treatment of medullary, follicular, Hurthle cell, or papillary thyroid carcinoma

B. Non-small cell lung cancer (NSCLC)
Authorization of 12 months may be granted for the treatment of NSCLC with RET gene rearrangements.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria.

IV. REFERENCES

1. Cometriq [package insert]. South San Francisco, CA: Exelixis; October 2017.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed November 24, 2017.
3. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology® Thyroid Carcinoma (Version 1.2016). http://www.nccn.org. Accessed November 27, 2017.
4. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology® Non-Small Cell Lung Cancer (Version 1.2018). http://www.nccn.org. Accessed November 27, 2017.