UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2018 P 1021-6
Program	Prior Authorization/Notification
Medication	Cometriq® (cabozantinib)
P&T Approval Date	02/2013, 07/2013, 8/2014, 8/2015, 6/2016, 6/2017, 6/2018
Effective Date	9/1/2018; Oxford only: 9/1/2018

1. Background:

Cometriq® (cabozantinib) is a kinase inhibitor indicated for the treatment of patients with progressive, metastatic medullary thyroid cancer (MTC).[1]

In addition, the National Cancer Comprehensive Network (NCCN) recommends Cometriq for the treatment of medullary, follicular, hürthle and papillary thyroid carcinomas. NCCN also recommends Cometriq for the treatment of non-small cell lung cancer (NSCLC) with RET gene rearrangement.[2]

Coverage Information:

Members will be required to meet the criteria below for coverage. For members under the age of 19 years, the prescription will automatically process without a coverage review.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

2. Coverage Criteria:

A. <u>Patients less than 19 years of age</u>

1. **Cometriq** will be approved based on the following criterion**:**

   a. Patient is less than 19 years of age

Authorization will be issued for 12 months.

B. <u>Thyroid Cancer</u>

1. <u>Initial Authorization</u>

a. **Cometriq** will be approved based on the following criterion:

(1) Diagnosis of **<u>one</u>** of the following:

i. Medullary carcinoma

ii. Follicular carcinoma (off-label)
iii. Hürthle cell carcinoma (off-label)
iv. Papillary carcinoma (off-label)

Authorization will be issued for 12 months.

2. Reauthorization

a. **Cometriq** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Cometriq therapy

Authorization will be issued for 12 months.

C. Non-Small Cell Lung Cancer (NSCLC) (off-label)

1. Initial Authorization

a. **Cometriq** will be approved based on **both** of the following criteria:

(1) Diagnosis of non-small cell lung cancer (NSCLC)

-AND-

(2) Positive for RET gene rearrangements

Authorization will be issued for 12 months.

2. Reauthorization

a. **Cometriq** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Cometriq therapy

Authorization will be issued for 12 months.

3. Additional Clinical Rules:

- Supply limits may be in place.

4. References:

1. Cometriq [prescribing information]. South San Francisco, CA: Exelixis, Inc.; January 2018.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed April 19, 2018.

Program	Prior Authorization/Notification - Cometriq (cabozantinib)
Change Control	
7/2013	Review of clinical criteria. No change to coverage. Updated formatting.
8/2014	Annual review. Added coverage for NSCLC, clarified thyroid cancer, updated formatting, Background and References.
8/2015	Annual review with no change to clinical criteria. Increased authorization and reauthorization from 11 months to 12 months for all indications. Updated references.
6/2016	Annual review. Updated MTC clinical criteria to include only a diagnosis of MTC. Updated background, formatting and references.
6/2017	Annual review. Changed MTC clinical criteria to Thyroid Cancer to include NCCN expanded thyroid cancer indications. Updated background, formatting and references.
6/2018	Annual review. Updated references.