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, Hürthle cell, and papillary thyroid carcinoma
2. Non-small cell lung cancer with RET gene arrangements

All other indications are considered experimental/investigational and not medically necessary.

II. DOCUMENTATION

Submission of RET gene rearrangement documentation is necessary to initiate the prior authorization review for the indication of non-small cell lung cancer.

III. CRITERIA FOR INITIAL APPROVAL

A. Thyroid carcinoma
Authorization of 12 months may be granted for treatment of thyroid carcinoma when any of the following criteria are met:
1. Member has follicular, Hürthle cell, or papillary thyroid carcinoma that is not amenable to radioactive iodine (RAI) therapy.
2. Member has medullary thyroid carcinoma.

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

IV. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Section III when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

V. REFERENCES

1. Cometriq [package insert]. South San Francisco, CA: Exelixis; October 2020.
2. The NCCN Drugs & Biologics Compendium® © 2020 National Comprehensive Cancer Network, Inc. Available at: https://www.nccn.org. Accessed November 6, 2020.