BlueCross BlueShield of Arizona
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PHARMACY COVERAGE GUIDELINES	**ORIGINAL EFFECTIVE DATE: 1/01/16**
SECTION: DRUGS	**LAST REVIEW DATE: 9/20/18**
	LAST CRITERIA REVISION DATE: 9/20/18
	ARCHIVE DATE:

COMETRIQ™ (cabozantinib) oral capsule

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

COMETRIQ™ (cabozantinib) oral capsule (cont.)

Criteria:

- **Criteria for initial therapy:** Cometriq (cabozantinib) oral capsule is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Provider is an Oncologist
  2. Individual is 18 years of age or older
  3. A confirmed diagnosis of **ONE** of the following:
     - Medullary thyroid cancer (MTC) that is either:
       - Unresectable locoregional disease that is symptomatic or progressing
       - Asymptomatic recurrent or persistent distant metastases if unresectable and progressing
       - Recurrent or persistent distant metastases if symptomatic disease or progression
     - Papillary, follicular, or Hurthle Cell thyroid carcinoma if other systemic therapies are not available or appropriate for progressive and/or symptomatic iodine refractory that is either:
       - Unresectable locoregional recurrent or persistent disease
       - Distant metastatic disease
     - Non-small cell lung cancer with RET gene rearrangements that have histology types of adenocarcinoma (with mixed subtypes), large cell carcinoma, or squamous cell carcinoma
     - Other request for a specific oncologic direct treatment use that is found and listed in the National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1, 2A, or 2B
  4. There is no recent history of severe hemorrhage or hemoptysis
  5. There is no GI fistula or perforation
  6. The individual does not have severe hepatic impairment (Child-Pugh Class C)

  Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Cometriq (cabozantinib) oral capsule is considered ***medically necessary*** and will be approved with documentation of **ALL** of the following:

  1. Continues to be seen by an Oncologist
  2. The cancer has not progressed while on therapy
  3. Individual has been adherent with the medication

COMETRIQ™ (cabozantinib) oral capsule (cont.)

4. Individual has not developed any significant level 4 adverse drug effects that may exclude continued use, such as:
   - Severe bleeding
   - GI perforation or fistula
   - Arterial thrombotic events: MI, cerebral infarction, or other serious arterial thromboembolic events
   - Reversible Posterior leukoencephalopathy syndrome (RPLS)
   - Malignant hypertension, hypertensive crisis or severe hypertension that cannot be controlled with anti-hypertensive therapy
   - Osteonecrosis of jaw
   - Proteinuria or nephrotic syndrome

5. There are no significant interacting drugs

Renewal duration: 12 months

Description:

Cometriq (cabozantinib) capsule is a kinase inhibitor indicated for the treatment of patients with progressive, metastatic medullary thyroid cancer (MTC). Cabozantinib is also available as a tablet, under the brand name of Cabometyx®, which is indicated for the treatment of patients with advanced renal cell carcinoma (RCC) who have received prior anti-angiogenic therapy. These dosage forms are not interchangeable due to differences in the pharmacokinetics of each formulation.

Thyroid cancer is the most common of the endocrine malignancies. The annual incidence of thyroid cancer varies considerably by geographic area, age and sex. The only recognized environmental risk factor for thyroid carcinoma is exposure to ionizing radiation.

Thyroid cancer can develop from follicular or non-follicular thyroid cells. Medullary thyroid cancer (MTC) arises from non-follicular thyroid cells called calcitonin-producing cells. Thyroid cancers from follicular cells include papillary thyroid cancer (PTC), follicular thyroid cancer (FTC), Hurthle cell cancer (HCC, also known as oxyphil thyroid cancer, a subtype of FTC), and anaplastic thyroid cancer (ATC). PTC and FTC are often referred to as differentiated thyroid cancer (DTC). There are several subtypes of DTC that includes tall cell, columnar and insular thyroid cancers. ATC is an undifferentiated thyroid cancer.

Cabozantinib inhibits the tyrosine kinase activity of MET, VEGFR-1, -2 and -3, AXL, RET, ROS1, TYRO3, MER, KIT, TRKB, FLT-3, and TIE-2. These receptor tyrosine kinases are involved in both normal cellular function and pathologic processes such as oncogenesis, metastasis, tumor angiogenesis, drug resistance, and maintenance of the tumor microenvironment.

Resources:

Cometriq. Package Insert. Revised by manufacturer 01/2018. Accessed 07-19-2018.

COMETRIQ™ (cabozantinib) oral capsule (cont.)

Cometriq. Package Insert. Revised by manufacturer 11/2012. Accessed 09-04-2015.

Cometriq. Package Insert. Revised by manufacturer 1/2018. Accessed 08-17-2018.

UpToDate: Medullary thyroid cancer: Chemotherapy and immunotherapy. Current through July 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/medullary-thyroid-cancer-chemotherapy-and-immunotherapy?source=search_result&search=medullary%20thyroid%20cancer&selectedTitle=3~64

NCCN Clinical Practice Guidelines in Oncology: Thyroid Carcinoma. Version 2.2017, May 17, 2017. https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf

NCCN Clinical Practice Guidelines in Oncology: Thyroid Carcinoma. Version 1.2018, May 22, 2018. https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf

NCCN Clinical Practice Guidelines in Oncology: Non-Small Cell Lung Cancer. Version 6.2018, Aug 17, 2018. https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.

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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information

Medication Name:	Strength:	Dosage Form:
Directions for Use:	Quantity: / Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. **What is the diagnosis? Please specify below.**

   ICD-10 Code: _____ **Diagnosis Description:** _____

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. **Are there any supporting labs or test results? Please specify below.**

Date	Test	Value

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Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form.

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Office notes, labs, and medical testing relevant to the request that show medical justification are required.