



An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINES  
SECTION: DRUGS

ORIGINAL EFFECTIVE DATE: 8/20/2020  
LAST REVIEW DATE:  
LAST CRITERIA REVISION DATE:  
ARCHIVE DATE:

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## TABRECTA™ (capmatinib) oral

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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.

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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](http://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](mailto:Pharmacyprecert@azblue.com). **Incomplete forms or forms without the chart notes will be returned.**



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### Criteria:

- **Criteria for initial therapy:** Tabrecta (capmatinib) is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:
1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with an Oncologist
  2. Individual is 18 years of age or older
  3. A confirmed diagnosis of **ONE** of the following:
    - a. Recurrent, advanced or metastatic non-small cell lung cancer (NSCLC) whose tumor has a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping as first-line therapy or subsequent therapy following progression on systemic therapy with a non-MET exon 14 skipping regimen
    - b. 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 and 2A
  4. **ALL** of the following **baseline tests** have been completed before initiation of treatment with continued monitoring as clinically appropriate:
    - a. Positive test for tumor mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping
    - b. Liver function tests
    - c. Negative pregnancy test in a woman of child bearing potential
    - d. Eastern Cooperative Oncology Group Performance Status of 0-1

**Initial approval duration:** 6 months

- **Criteria for continuation of coverage (renewal request):** Tabrecta (capmatinib) is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:
1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with an Oncologist
  2. Individual's condition responded while on therapy
    - a. Response is defined as:
      - i. Documented evidence disease stability
      - ii. No evidence of disease progression
  3. Individual has been adherent with the medication
  4. Dose is at least 200 mg twice daily
  5. Individual has not developed any significant level 4 adverse drug effects that may exclude continued use



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- a. Significant adverse effect such as:
  - i. Interstitial lung disease/pneumonitis
  - ii. Hepatotoxicity
- 6. There are no significant interacting drugs

**Renewal duration:** 12 months

### Description:

Tabrecta (capmatinib) is a kinase inhibitor indicated for the treatment of adult patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping as detected by an FDA-approved test. This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).

Capmatinib targets MET, including the mutant variant produced by exon 14 skipping. MET exon 14 skipping results in a protein with a missing regulatory domain that reduces its negative regulation leading to increased downstream MET signaling. Through MET inhibition, capmatinib decreases cancer cell growth.

### Definitions:

#### **Common Terminology Criteria for Adverse Events (CTCAE) Version 4.0:**

Grade 1	Mild; asymptomatic or mild symptoms; clinical or diagnostic observations only; intervention not indicated
Grade 2	Moderate; minimal, local or noninvasive intervention indicated; limiting age-appropriate instrumental ADL*
Grade 3	Severe or medically significant but not immediately life-threatening; hospitalization or prolongation of hospitalization indicated; disabling; limiting self-care ADL**
Grade 4	Life-threatening consequences; urgent intervention indicated
Grade 5	Death related to AE
U.S. department of Health and Human Services, National Institutes of Health, and National Cancer Institute	

### Activities of daily living (ADL):

Instrumental ADL:

Prepare meals, shop for groceries or clothes, use the telephone, manage money, etc.

Self-care ADL:

Bathe, dress and undress, feed self, use the toilet, take medications, not bedridden



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### ECOG Performance status:

Eastern Co-operative Oncology Group (ECOG) Performance Status	
Grade	ECOG description
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours
3	Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours
4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
5	Dead
Oken, M.M., Creech, R.H., Tormey, D.C., Horton, J., Davis, T.E., McFadden, E.T., Carbone, P.P.: Toxicity And Response Criteria Of The Eastern Cooperative Oncology Group. Am J Clin Oncol 5:649-655, 1982	

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### Resources:

Tabrecta (capmatinib) product information, revised by manufacturer 05-2020, accessed 05-20-20 at DailyMed

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology: Non-Small Cell Lung Cancer. Version 06.2020, June 15, 2020. Accessed 07-14-20

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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