UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1196-11
Program	Prior Authorization/Notification
Medication	Cabometyx® (cabozantinib)
P&T Approval Date	6/2016, 6/2017, 2/2018, 6/2018, 3/2019, 3/2020, 3/2021, 11/2021, 11/2022, 11/2023, 11/2024
Effective Date	2/15/2025

1. Background:

Cabometyx® (cabozantinib) is a kinase inhibitor indicated for the treatment of patients with advanced renal cell carcinoma (RCC), patients with advanced RCC as a first-line treatment in combination with Opdivo (nivolumab), patients with hepatocellular carcinoma (HCC) who have been previously treated with Nexavar® (sorafenib tosylate), and in adult and pediatric patients 12 years of age and older with locally advanced or metastatic differentiated thyroid cancer (DTC) that has progressed following prior VEGFR-targeted therapy and who are radioactive iodine-refractory or ineligible.

The National Cancer Comprehensive Network (NCCN) recommends Cabometyx for the treatment of non-small cell lung cancer (NSCLC) with RET gene rearrangement and HCC as a single agent for progressive disease. Cabometyx is also recommended in NCCN guidelines for bone cancer, gastrointestinal stromal tumors (GIST), kidney cancer, soft tissue sarcoma, and endometrial carcinoma.

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]:

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

1. **Cabometyx** 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>Kidney Cancer</u>

1. **<u>Initial Authorization</u>**

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

(1) Diagnosis of **one** of the following:

(a) Stage IV or relapsed renal cell carcinoma (RCC)
(b) Hereditary leiomyomatosis and RCC (HLRCC)

Authorization will be issued for 12 months.

2. **Reauthorization**

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

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

Authorization will be issued for 12 months.

C. Non-Small Cell Lung Cancer (NSCLC)

1. **Initial Authorization**

a. **Cabometyx** will be approved based on **all** of the following criteria:

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

-AND-

(2) Positive for RET gene rearrangements

-AND-

(3) Disease is **one** of the following:

(a) Recurrent
(b) Advanced
(c) Metastatic

Authorization will be issued for 12 months.

2. **Reauthorization**

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

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

Authorization will be issued for 12 months.

D. Hepatocellular Carcinoma

1. **Initial Authorization**

   a. **Cabometyx** will be approved based on **all** of the following criteria:

      (1) Diagnosis of hepatocellular carcinoma

      -AND-

      (2) Used as subsequent-line systemic therapy

      -AND-

      (3) **One** of the following:

         (a) Patient has liver-confined, unresectable disease and is not a transplant candidate

         (b) Patient has extrahepatic/metastatic disease and deemed ineligible for resection, transplant, or locoregional therapy

   Authorization will be issued for 12 months.

2. **Reauthorization**

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

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

   Authorization will be issued for 12 months.

E. Bone Cancer

1. **Initial Authorization**

   a. **Cabometyx** will be approved based on **all** of the following criteria:

      (1) **One** of the following diagnoses:

         (a) Osteosarcoma

         (b) Ewing Sarcoma (including mesenchymal chondrosarcoma)

      -AND-

      (2) Disease is **one** of the following:

         (a) Relapsed/refractory

(b) Metastatic

-AND-

(3) Used as second line therapy

Authorization will be issued for 12 months.

2. **Reauthorization**

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

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

Authorization will be issued for 12 months.

F. Gastrointestinal Stromal Tumors (GIST)

1. **Initial Authorization**

a. **Cabometyx** will be approved based on **all** the following criteria:

(1) Diagnosis of GIST

-AND-

(2) Patient has **one** of the following:

(a) Gross residual disease (R2 resection)
(b) Unresectable primary disease
(c) Tumor rupture
(d) Recurrent/metastatic disease

-AND-

(3) Disease has progressed on **all** of the following:

(a) Gleevec (imatinib)
(b) Sutent (sunitinib)
(c) Stivarga (regorafenib)
(d) Standard dose Qinlock (ripretinib)

Authorization will be issued for 12 months.

2. **Reauthorization**

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

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

Authorization will be issued for 12 months.

G. Endometrial Carcinoma

1. **Initial Authorization**

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

      (1) Diagnosis of endometrial carcinoma

      -AND-

      (2) Used as second-line or subsequent treatment

   Authorization will be issued for 12 months.

2. **Reauthorization**

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

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

   Authorization will be issued for 12 months.

H. Thyroid Cancer

1. **Initial Authorization**

   a. **Cabometyx** will be approved based on **all** of the following:

      (1) Diagnosis of differentiated thyroid cancer (DTC)

      -AND-

      (2) Disease is locally advanced or metastatic

      -AND-

      (3) Disease has progressed following prior VEGFR-targeted therapy

      -AND-

      (4) Disease is radioactive iodine-refractory or ineligible

   Authorization will be issued for 12 months.

2. **Reauthorization**

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

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

Authorization will be issued for 12 months.

I. Soft Tissue Sarcoma

1. **Initial Authorization**

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

(1) **One** of the following soft tissue sarcoma subtypes:

(a) Alveolar soft part sarcoma (ASPS)
(b) Atypical lipomatous tumor/well-differentiated liposarcoma (ALT/WDLPS)
(c) Clear cell sarcoma
(d) Extraskeletal myxoid chondrosarcoma

-AND-

(2) Used as subsequent line of therapy for advanced/metastatic disease

Authorization will be issued for 12 months.

2. **Reauthorization**

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

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

Authorization will be issued for 12 months.

J. NCCN Recommended Regimens

The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Cabometyx [prescribing information]. South San Francisco, CA: Exelixis, Inc.; September 2023.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed September 25, 2024.

Program	Prior Authorization/Notification – Cabometyx (cabozantinib)
Change Control	
6/2016	New program.
6/2017	Annual review with no changes to clinical criteria.
2/2018	Updated background and criteria to include new indication for first line therapy for RCC. Added coverage for NCCN recommended use for NSCLC.
6/2018	Annual review with no changes to clinical criteria.
3/2019	Updated background and criteria to include new indication for second line therapy for HCC and NCCN recommended use for HCC.
3/2020	Annual review. Updated RCC criteria to only require a diagnosis of advanced renal cell carcinoma to align with label. Added standard language for NCCN recommended regimens.
3/2021	Annual review. Updated background and criteria to include new NCCN recommendations for osteosarcoma, Ewing sarcoma, GIST and kidney cancer.
11/2021	Updated background and criteria to include Endometrial carcinoma and new indication for thyroid cancer. Updated references.
11/2022	Annual review. Updated examples of approved therapies for GIST per NCCN without change to clinical intent. Added state mandate and updated references.
11/2023	Annual review. Updated NSCLC, hepatocellular carcinoma, and GIST criteria per NCCN recommendation. Updated background. Updated references.
11/2024	Annual review. Consolidated sections and updated coverage criteria for kidney cancer and renal cell carcinoma into kidney cancer. Consolidated sections and updated coverage criteria for ewing sarcoma and osteosarcoma into bone cancer. Added criteria for soft tissue sarcoma per NCCN guideline. Updated coverage criteria for

	hepatocellular carcinoma and endometrial carcinoma. Updated background.