



STANDARD COMMERCIAL DRUG FORMULARY  
PRIOR AUTHORIZATION GUIDELINES

**CABOZANTINIB S-MALATE**

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
CABOZANTINIB S-MALATE	COMETRIQ, CABOMETYX	39815		GPI-10 (2153301010)	

**\*\* Please use the criteria for the specific drug requested \*\***

**GUIDELINES FOR USE**

**COMETRIQ**

1. Does the patient have a diagnosis of progressive, metastatic medullary thyroid cancer (MTC)?

If yes, **approve for 12 months by GPID or GPI-14 with a quantity limit of #112 per 28 days for the requested daily dose pack. (NOTE: Cometriq is available in three dosage packs each containing 7 days supply)**

- **Cometriq 140mg daily dose pack.**
- **Cometriq 100mg daily dose pack.**
- **Cometriq 60mg daily dose pack.**

If no, do not approve.

**DENIAL TEXT: \*Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.**

Our guideline named **CABOZANTINIB S-MALATE (Cometriq)** requires the following rule be met for approval:

A. You have progressive, metastatic medullary thyroid cancer (type of thyroid cancer that has spread)

Your doctor told us **[INSERT PT SPECIFIC INFO PROVIDED]**. We do not have information showing you **[INSERT UNMET CRITERIA]**. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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GUIDELINES FOR USE (CONTINUED)

CABOMETYX

1. Does the patient have a diagnosis of advanced renal cell carcinoma (RCC) and meet **ONE** of the following criteria?
  - Cabometyx will be used as a single agent
  - Cabometyx will be used in combination with Opdivo (nivolumab) as first-line treatment (no prior treatment for advanced RCC)

If yes, **approve for 12 months by GPID or GPI-14 for the requested strength with the following quantity limits:**

- Cabometyx 60mg: #1 per day.
- Cabometyx 40mg: #2 per day.
- Cabometyx 20mg: #1 per day.

If no, continue to #2.

2. Does the patient have a diagnosis of hepatocellular carcinoma (HCC) **AND** meet the following criterion?
  - The patient has previously been treated with Nexavar (sorafenib)

If yes, **approve for 12 months by GPID or GPI-14 for the requested strength with the following quantity limits:**

- Cabometyx 60mg: #1 per day.
- Cabometyx 40mg: #2 per day.
- Cabometyx 20mg: #1 per day.

If no, continue to #3.

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GUIDELINES FOR USE - CABOMETYX (CONTINUED)

3. Does the patient have a diagnosis of locally advanced or metastatic differentiated thyroid cancer (DTC) and meet **ALL** of the following criteria?
- The patient is 12 years of age or older
  - The patient has disease progression following prior vascular endothelial growth factor receptor (VEGFR)-targeted therapy
  - The patient is radioactive iodine-refractory or ineligible

If yes, **approve for 12 months by GPID or GPI-14 for the requested strength with the following quantity limits:**

- Cabometyx 60mg: #1 per day.
- Cabometyx 40mg: #2 per day.
- Cabometyx 20mg: #1 per day.

If no, do not approve.

**DENIAL TEXT: \*Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.**

Our guideline named **CABOZANTINIB S-MALATE (Cabometyx)** requires the following rule(s) be met for approval:

- A. You have **ONE** of the following diagnoses:
1. Advanced renal cell carcinoma (RCC: type of kidney cancer)
  2. Hepatocellular carcinoma (HCC: type of liver cancer)
  3. Locally advanced or metastatic differentiated thyroid cancer (DTC: type of thyroid cancer)
- B. **If you have advanced renal cell carcinoma, approval also requires ONE of the following:**
1. Cabometyx will be used as a single agent (used alone)
  2. Cabometyx will be used in combination with Opdivo (nivolumab) as first-line treatment (You have not received prior treatment for advanced renal cell carcinoma)
- C. **If you have hepatocellular carcinoma, approval also requires:**
1. You have previously been treated with Nexavar (sorafenib)
- D. **If you have locally advanced or metastatic differentiated thyroid cancer, approval also requires:**
1. You are 12 years of age or older
  2. You have disease progression (disease has gotten worse) following prior vascular endothelial growth factor receptor (VEGFR)-targeted therapy (a type of cancer therapy)
  3. You are radioactive iodine-refractory (resistant to) or ineligible

Your doctor told us **[INSERT PT SPECIFIC INFO PROVIDED]**. We do not have information showing you **[INSERT UNMET CRITERIA]**. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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**RATIONALE**

For further information, please refer to the Prescribing Information and/or Drug Monograph for Cometriq or Cabometyx.

**REFERENCES**

- Cometriq [Prescribing Information]. South San Francisco, CA: Exelixis, Inc.; February 2020.
- Cabometyx [Prescribing Information]. South San Francisco, CA: Exelixis, Inc.; September 2021.

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Yes	Yes	No

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