



STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

CABOZANTINIB S-MALATE

Generic	Brand	HICL	GCN	Exception/Other
CABOZANTINIB S-MALATE	COMETRIQ, CABOMETYX	39815		

**** 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 with a quantity limit of #112 capsules 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 (GPID 33903): Seven 80mg capsules and twenty one 20mg capsules.**
- **Cometriq 100mg daily dose pack (GPID 33904): Seven 80mg capsules and seven 20mg capsules.**
- **Cometriq 60mg daily dose pack (GPID 33905): Twenty one 20mg capsules.**

If no, do not approve.

DENIAL TEXT: The guideline named **CABOZANTINIB S-MALATE (Cometriq)** requires a diagnosis of progressive, metastatic medullary thyroid cancer (MTC).

CABOMETYX

1. Does the patient have a diagnosis of advanced renal cell carcinoma (RCC)?

If yes, **approve for 12 months by GPID for the requested strength with the applicable quantity limit:**

- **Cabometyx 60mg tablet (GPID 41148): #1 tablet per day.**
- **Cabometyx 40mg tablet (GPID 41147): #2 tablets per day.**
- **Cabometyx 20mg tablet (GPID 41146): #1 tablet per day.**

If no, continue to #2.

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GUIDELINES FOR USE - CABOMETYX (CONTINUED)

2. Does the patient have a diagnosis of hepatocellular carcinoma (HCC) AND meet the following criterion?

- Patient has previously been treated with Nexavar (sorafenib)

If yes, **approve for 12 months by GPID for the requested strength with the applicable quantity limit:**

- Cabometyx 60mg tablet (GPID 41148): #1 tablet per day.
- Cabometyx 40mg tablet (GPID 41147): #2 tablets per day.
- Cabometyx 20mg tablet (GPID 41146): #1 tablet per day.

If no, do not approve.

DENIAL TEXT: The guideline named **CABOZANTINIB S-MALATE (Cabometyx)** requires a diagnosis of advanced renal cell carcinoma (RCC) or hepatocellular carcinoma (HCC). In addition, the following criteria must be met:

For patients with hepatocellular carcinoma (HCC), approval requires:

- The patient has previously been treated with Nexavar (sorafenib)

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.; January 2018.
- Cabometyx [Prescribing Information]. South San Francisco, CA: Exelixis, Inc.; January 2019.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A

Commercial Effective: 10/01/19

Created: 01/13

Client Approval: 09/19

P&T Approval: 01/19