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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CABOZANTINIB S-MALATE

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
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P&T Approval: 01/19