Criteria Based Consultation Prescribing Program

CRITERIA FOR DRUG COVERAGE

cabozantinib (Cometriq)

**Initial approval criteria:** Non-formulary cabozantinib (Cometriq) will be covered on the prescription drug benefit for 12 months when the following criteria are met:

- Prescribed by an Oncologist or Hematologist
- AND-
- Patient age is 18 years or older
- AND-
- Patient does not have a recent history of severe hemorrhage (*bleeding*)
- AND-
- Patient does not have a recent history of gastrointestinal perforations and/or fistula
- AND-
- Patient has one of the following diagnoses:
  1) Medullary thyroid carcinoma -AND-
     - Is progressive, or metastatic -OR-
     - Is unresectable, symptomatic, or progressive locoregional disease
     -OR-
  2) Follicular, Hürthle Cell or Papillary thyroid carcinoma -AND-
     - Is progressive and/or symptomatic iodine-refractory disease -AND-
     - Is unresectable recurrent, persistent, or metastatic disease
     -OR-
  3) Non-small cell lung cancer -AND-
     - Positive for RET gene rearrangement

**Continued use criteria:** Non-formulary cabozantinib (Cometriq) will continue to be covered on the prescription drug benefit for 12 months when the following criteria are met:

- Patient does not show evidence of progressive disease while on cabozantinib therapy
- AND-
- Absence of unacceptable toxicity associated with cabozantinib