Clinical Policy: Cabozantinib (Cometriq, Cabometyx)

Reference Number: CP.PHAR.111
Effective Date: 06/13
Last Review Date: 04/17

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
The intent of the criteria is to ensure that patients follow selection elements established by Centene® clinical policy for cabozantinib (Cometriq™, Cabometyx™).

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that Cometriq and Cabometyx are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Medullary Thyroid Cancer (must meet all):
1. Diagnosis of progressive, metastatic medullary thyroid cancer;
2. Request is for Cometriq;
3. Member does not have a recent history of hemorrhage or hemoptysis;
4. Prescribed dose of Cometriq does not exceed the following (a or b):
   a. 140 mg per day;
   b. If taking a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, phenobarbital): 180 mg per day.

Approval Duration: 6 months

B. Renal Cell Carcinoma (must meet all):
1. Diagnosis of advanced renal cell carcinoma;
2. Request is for Cabometyx;
3. Member has received prior anti-angiogenic therapy (e.g., Votrient; Sutent; Inlyta; Nexavar; Avastin in combination with interferon alfa);
4. Prescribed dose of Cabometyx does not exceed the following (a or b):
   a. 60 mg per day;
   b. If taking a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, phenobarbital): 80 mg per day.

Approval Duration: 6 months

C. Other diagnoses/indications: Refer to CP.PHAR.57 - Global Biopharm Policy.
1. Additional Cometriq uses, as outlined in the NCCN compendium and meeting NCCN category 1, 2a, or 2b, are covered for the following indications per the CP.PHAR.57 Global Biopharm Policy:
   a. Non-small cell lung cancer.

II. Continued Approval

A. Medullary Thyroid Cancer (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Documentation of positive response to therapy (e.g.: no disease progression, no unacceptable toxicity);
3. Prescribed dose of Cometriq does not exceed the following (a or b):
   a. 140 mg per day;
   b. If taking a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, phenobarbital): 180 mg per day.

Approval Duration: 12 months

B. Renal Cell Carcinoma
1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Documentation of positive response to therapy (e.g.: no unacceptable toxicity; attestation that member continues to experience clinical benefit from therapy);
3. Prescribed dose of Cabometyx does not exceed the following (a or b):
   a. 60 mg per day;
   b. If taking a strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, phenobarbital): 80 mg per day.

Approval Duration: 12 months

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy; or
2. Refer to CP.PHAR.57 - Global Biopharm Policy**.**

Background

Description/Mechanism of Action:
Cabozantinib is an oral kinase inhibitor. In vitro biochemical and/or cellular assays have shown that cabozantinib inhibits the tyrosine kinase activity of RET, MET, VEGFR-1, -2 and -3, KIT, TRKB, FLT-3, AXL, and TIE-2. These receptor tyrosine kinases are involved in both normal cellular function and pathologic processes such as oncogenesis, metastasis, tumor angiogenesis, and maintenance of the tumor microenvironment.

Formulations:
Cabozantinib (Cometriq) capsules: 20 mg and 80 mg
Cabozantinib (Cabometyx) tablets: 20 mg, 40 mg, and 60 mg

FDA Approved Indication:
Cometriq is a kinase inhibitor/oral capsule indicated for:
- Treatment of patients with progressive, metastatic medullary thyroid cancer.

Cabometyx is a kinase inhibitor/oral tablet indicated for:

- Treatment of patients with advanced renal cell carcinoma who have received prior anti-angiogenic therapy.

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J8999	Prescription drug, oral, chemotherapeutic, NOS

Reviews, Revisions, and Approvals	Date	Approval Date
Removed prospective monitoring questions and changed it to Appendix A and related question for denial of existing conditions. Updated background and safety information.	05/14	05/14
Updated clinical background and safety section.	03/15	04/15
Policy converted to new template. Criteria: added age and max dose requirements per PI; added moderate to severe hepatic impairment to contraindications per PI; changed initial approval duration to 3 months; added disease progression to reasons to discontinue per NCCN thyroid carcinoma guidelines which present alternative TKIs in such cases.	03/16	04/16
Updated policy title to include Cabometyx. MTC initial: removed requirements related to age and hepatic function; modified max dose requirement to include usual max dose. Re-auth: added max dose; removed safety criteria. Created criteria for RCC. Added additional Cometriq/Cabometyx uses as outlined per NCCN compendium under section IC: Other diagnoses/indications.	03/17	04/17

References
1. Cometriq Prescribing Information. South San Francisco, CA: Exelixis, Inc.; May 2016. Available at http://www.cometriq.com/. Accessed March 22, 2017.
2. Cabometyx Prescribing Information. South San Francisco, CA: Exelixis, Inc.; April 2016. Available at: https://www.cabometyx.com/. Accessed March 28, 2017.
3. Cabozantinib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.NCCN.org. Accessed March 22, 2017.

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical

information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.