Cabometyx (cabozantinib)
Effective 01/15/2021

Plan	☒ MassHealth ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview

CABOMETYX is a prescription medicine used to treat:

- Patients with advanced kidney cancer (renal cell carcinoma)
- Patients with liver cancer (hepatocellular carcinoma) who have been previously treated with the medicine sorafenib

Coverage Guidelines

Authorization may be reviewed on a case by case basis for members who are currently receiving treatment with Cabometyx, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

OR

Authorization may be granted if the member meets **ALL** following criteria and documentation has been submitted:

Advanced renal cell carcinoma:

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Prescriber is an oncologist
3. Appropriate dosing
4. **ONE** of the following:
    a. Member has poor/intermediate risk and the request is for first-line treatment of clear cell histology
    b. Member has favorable risk and clear cell histology and inadequate response or adverse reaction to **ONE** or contraindication to **BOTH** of the following:
        i. Votrient® (pazopanib)

ii. Sutent® (sunitinib)

c. Member has clear cell histology and has received a previous treatment in the metastatic setting (*Example of previous treatments include Inlyta® (axitinib) + Keytruda® (pembrolizumab), Sutent® (sunitinib), Votrient® (pazopanib), and Yervoy® (ipilimumab) + Opdivo® (nivolumab). Other treatment options may be found in the NCCN guideline.)*

d. Member has non-clear cell histology and member has an inadequate response, adverse reaction, or contraindication to Sutent® (sunitinib)

5. Quantity requested is ≤1 tablet/day*

Unresectable Hepatocellular Carcinoma (HCC)

Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis
2. Prescriber is an oncologist
3. Appropriate dosing
4. Inadequate response, adverse reaction, or contraindication to Nexavar® (sorafenib)
5. Quantity requested is ≤1 tablet/day

Continuation of Therapy

Reauthorization requires physician attestation of continuation of therapy and positive response to therapy.

Limitations

1. Initial approvals and reauthorizations will be granted for 12 months
2. The following quantity limits apply:

Cabometyx	30 tablets per 30 days

*Any requests for over the quantity limit must be reviewed against the Global Quantity Limit criteria.

References

1. Cabometyx [package insert]. Alameida, CA: Exelixis; July 2020.

Review History

10/9/2020: Created criteria to be in compliance with the Masshealth partial unified formulary requirements effective 1/1/21.

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