Cabometyx (cabozantinib)  
Effective 01/15/2021

| Plan |  ☒ MassHealth  
| Benefit |  ☐ Commercial/Exchange | Program Type |  ☒ Prior Authorization  
|  ☒ Pharmacy Benefit  
|  ☐ Medical Benefit (NLX) |  ☐ Quantity Limit  
|  ☐ Step Therapy |

**Specialty Limitations:** This medication has been designated specialty and must be filled at a contracted specialty pharmacy.

| 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)

399 Revolution Drive, Suite 810, Somerville, MA 02145 | allwayshealthpartners.org
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

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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