Medullary Thyroid Cancer Agents
Caprelsa® (vandetanib)
Cometriq® (cabozantinib)
Effective 01/01/2022

Plan	☐ MassHealth ☒ MassHealth (PUF) ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	These medications have 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
Medullary thyroid cancer agents

Reference Table:

No PA	Drugs that require PA
	Caprelsa® (vandetanib)
	Cometriq® (cabozantinib capsule)

Coverage Guidelines
Authorizations requests will be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Caprelsa® (vandetanib)
Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis: Symptomatic or progressive medullary thyroid cancer
2. **ONE** of the following:
    a. Request is within quantity limit of 30 units/30 days for 300 mg tablets or 60 units/30 days for 100 mg tablets
    b. Medical necessity for exceeding quantity limit of 30 units/30 days for 300 mg tablets or 60 units/30 days for 100 mg tablets

Cometriq® (cabozantinib capsule)
Prescriber provides documentation of **ALL** of the following:

1. Appropriate diagnosis: Symptomatic or progressive medullary thyroid cancer
2. **ONE** of the following:
    a. Requested dose does not exceed 140 mg/day
    b. Medical necessity for exceeding the 140 mg/day dose

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

Limitations

1. Initial authorizations will be for 3 months
2. Reauthorizations will be granted for 6 months

References

1. Caprelsa [prescribing information],June 2020, Genzyme Corporation, Cambridge, MA 02142.
2. Cometriq (cabozantinib) capsule [prescribing information]. Alameda, CA: Exelixis Inc; October 2020.

Review History
11/17/2022 – Created and Reviewed Nov P&T; alignment with the MassHealth Uniform formulary. Effective 01/01/2022

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