

SPECIALTY GUIDELINE MANAGEMENT

CABOMETYX (cabozantinib)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

- A. FDA-Approved Indication¹
Advanced renal cell carcinoma (RCC)
- B. Compendial Uses²
 - 1. Relapse or stage IV kidney cancer
 - 2. Non-small cell lung cancer

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR INITIAL APPROVAL

- A. **Renal Cell Carcinoma**¹⁻³
Authorization of 12 months may be granted for treatment of relapsed, unresectable, or metastatic renal cell carcinoma.
- B. **Non-small Cell Lung Cancer**²
Authorization of 12 months may be granted for treatment of non-small cell lung cancer.

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Cabometyx [package insert]. South San Francisco, CA: Exelixis, Inc.; December 2017.
2. The NCCN Drugs & Biologics Compendium® © 2017 National Comprehensive Cancer Network, Inc. <http://www.nccn.org>. Accessed December 20, 2017.
3. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Kidney Cancer. Version 2.2017. Accessed July 24, 2017. https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf.