SPECIALTY GUIDELINE MANAGEMENT

CAPRELSA (vandetanib)

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 Indication
   1. Treatment of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease

B. Compendial Uses
   1. Follicular, Hurthle cell, and papillary thyroid carcinoma
   2. Non-small cell lung cancer with RET gene rearrangements

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

II. CRITERIA FOR INITIAL APPROVAL

A. **Thyroid Carcinoma**
Authorization of 12 months may be granted for the treatment of medullary, follicular, Hurthle cell, or papillary thyroid carcinoma

B. **Non-small Cell Lung Cancer**
Authorization of 12 months may be granted for the treatment of non-small cell lung cancer when the tumor expresses RET gene rearrangements

III. CONTINUATION OF THERAPY

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

IV. REFERENCES

1. Caprelsa [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals; July 2016.
2. The NCCN Drugs & Biologics Compendium™ © 2016 National Comprehensive Cancer Network, Inc. http://www.nccn.org. Accessed December 02, 2016.