Clinical Policy: Vandetanib (Caprelsa)  
Reference Number: ERX.SPA.82  
Effective Date: 03.01.14  
Last Review Date: 02.19

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Vandetanib (Caprelsa®) is a kinase inhibitor.

FDA Approved Indication(s)
Caprelsa is indicated for the treatment of symptomatic or progressive medullary thyroid cancer (MTC) in patients with unresectable locally advanced or metastatic disease. Use Caprelsa in patients with indolent, asymptomatic, or slowly progressing disease only after careful consideration of the treatment related risks of Caprelsa.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Caprelsa is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Thyroid Cancer (must meet all):
      1. Diagnosis of one of the following (a or b):
         a. Recurrent, unresectable or metastatic MTC;
         b. Differentiated thyroid carcinoma (DTC; i.e., follicular, Hurthle cell, or papillary thyroid carcinoma) (off-label);
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. If DTC, failure of Lenvima® or Nexavar® unless contraindicated or clinically significant adverse effects are experienced;  
         *Prior authorization may be required for Lenvima and Nexavar
      5. Request meets one of the following (a or b):
         a. Dose does not exceed 300 mg per day;
         b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

   Approval duration: Length of Benefit

   B. Non-Small Cell Lung Cancer (off-label) (must meet all):
      1. Diagnosis of non-small cell lung cancer (NSCLC);
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. Documentation of RET gene rearrangement;
      5. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

   Approval duration: Length of Benefit
C. Other diagnoses/indications
   1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III
      (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy
   A. All Indications in Section I (must meet all):
      1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or
documentation supports that member is currently receiving Caprelsa for a covered indication
and has received this medication for at least 30 days;
      2. Member is responding positively to therapy;
      3. If request is for a dose increase, request meets one of the following (a or b):
         a. New dose does not exceed 300 mg per day;
         b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant
off-label use (prescriber must submit supporting evidence).
   Approval duration: Length of Benefit

   B. Other diagnoses/indications (must meet 1 or 2):
      1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions
and documentation supports positive response to therapy.
      Approval duration: Duration of request or 6 months (whichever is less); or
      2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III
      (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:
   A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient
documentation of efficacy and safety according to the off-label use policy – ERX.PA.01 or
evidence of coverage documents.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   DTC: differentiated thyroid carcinoma
   FDA: Food and Drug Administration
   MTC: medullary thyroid carcinoma
   NSCLC: non-small cell lung cancer

   Appendix B: Therapeutic Alternatives
   This table provides a listing of preferred alternative therapy recommended in the approval criteria.
The drugs listed here may not be a formulary agent and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lenvima (lenvatinib)</td>
<td>DTC: 24 mg PO QD</td>
<td>24 mg/day</td>
</tr>
<tr>
<td>Nexavar (sorafenib)</td>
<td>DTC: 400 mg PO BID</td>
<td>400 mg/day</td>
</tr>
</tbody>
</table>

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic
(Brand name®) when the drug is available by both brand and generic.

   Appendix C: Contraindications/Boxed Warnings
   • Contraindication(s): congenital long QT syndrome
   • Boxed warning(s): QT prolongation, Torsades de pointes, sudden death

V. Dosage and Administration
<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTC</td>
<td>300 mg PO QD</td>
<td>300 mg/day</td>
</tr>
</tbody>
</table>

VI. Product Availability
   Tablets: 100 mg, 300 mg
VII. References

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created</td>
<td>02.14</td>
<td>03.14</td>
</tr>
<tr>
<td>Policy converted to new template. Criteria: added max dose; removed upper age limit, drug interaction, safety, and disease progression or unacceptable toxicity criteria.</td>
<td>07.16</td>
<td>09.16</td>
</tr>
<tr>
<td>-Converted to new template. -Extended continued approval from 6 to 12 months -Added NCCN recommendations -Added Black Box Warning info to Appendix</td>
<td>07.01.17</td>
<td>08.17</td>
</tr>
<tr>
<td>3Q 2018 annual review: added specialist involvement in care; differentiated thyroid cancers: added requirement for prior trials of lenvatinib and sorafenib and removed requirements for clinical trial appropriateness/prior trial of iodine; added off-label use for NSCLC; increased approval durations to length of benefit; added COC; references reviewed and updated.</td>
<td>06.27.18</td>
<td>08.18</td>
</tr>
<tr>
<td>1Q 2019 annual review: no significant changes; thyroid cancer diagnoses edited to reflect MTC vs. DTC for clarity and limited designation of advanced cancer to MTC while retaining a failed trial for DTC; references reviewed and updated.</td>
<td>11.13.18</td>
<td>02.19</td>
</tr>
</tbody>
</table>

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members.

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