

## PRIOR AUTHORIZATION POLICY

**POLICY:** Oncology – Caprelsa Prior Authorization Policy

- Caprelsa® (vandetanib tablets – AstraZeneca)

**REVIEW DATE:** 06/22/2022

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### OVERVIEW

Caprelsa, a kinase inhibitor, is indicated for the treatment of symptomatic or progressive **medullary thyroid cancer** in patients with unresectable locally advanced or metastatic disease.<sup>1</sup>

### Guidelines

Caprelsa is discussed in guidelines from the National Comprehensive Cancer Network (NCCN). NCCN thyroid guidelines (version 3.2022 – March 16, 2022) lists surgery as the main treatment option for medullary thyroid cancer.<sup>2,3</sup> Caprelsa (category 1) or Cometriq® (cabozantinib capsules) [category 1] are the preferred treatments for recurrent or persistent locoregional or distant metastatic disease. The guidelines recommend that Caprelsa can be considered if clinical trials or other systemic therapies are not available or appropriate for the treatment of progressive and/or symptomatic locally recurrent, advanced, and/or metastatic disease that is not amendable to radioactive iodine (RAI) therapy; this recommendation is for differentiated thyroid cancer (e.g. follicular, Hürthle cell, and papillary cancer subtypes) [all category 2A].<sup>2,3</sup>

### POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Caprelsa. All approvals are provided for the duration noted below.

**Automation:** None.

### RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Caprelsa is recommended in those who meet one of the following criteria:

#### FDA-Approved Indication

**1. Thyroid Carcinoma, Medullary.** Approve for 1 year if the patient is  $\geq 18$  years of age.

#### Other Uses with Supportive Evidence

**2. Thyroid Carcinoma, Differentiated.** Approve for 1 year if the patient meets the following criteria (A, B, and C):

A) Patient is  $\geq 18$  years of age; AND

B) Patient has differentiated thyroid carcinoma; AND

Note: Examples of differentiated thyroid carcinoma include papillary, follicular, and Hürthle cell thyroid carcinoma.

C) The disease is refractory to radioactive iodine therapy.

### CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Caprelsa is not recommended in the following situations:

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1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

#### **REFERENCES**

1. Caprelsa® tablets [prescribing information]. Wilmington, DE: AstraZeneca; June 2020.
2. The NCCN Thyroid Carcinoma Clinical Practice Guidelines in Oncology (version 2.2022 – May 5, 2022). © 2022 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed June 13, 2022.
3. The NCCN Drugs and Biologics Compendium. © 2022 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed June 13, 2022. Search term: vandetanib.