Reference number
1783-A

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
Treatment of symptomatic or progressive medullary thyroid cancer 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.

B. Compendial Uses
Follicular, oncocytic/Hürthle cell, and papillary thyroid carcinoma

All other indications are considered experimental/investigational and not medically necessary.

II. CRITERIA FOR INITIAL APPROVAL

Thyroid carcinoma
Authorization of 12 months may be granted for treatment of thyroid carcinoma when any of the following criteria are met:
A. Member has follicular, oncocytic/Hürthle cell, or papillary thyroid carcinoma that is not amenable to radioactive iodine (RAI) therapy.
B. Member has medullary thyroid carcinoma.

III. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting authorization for an indication listed in Section II when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

IV. REFERENCES

1. Caprelsa [package insert]. Cambridge, MA: Genzyme Corporation; December 2022.
2. The NCCN Drugs & Biologics Compendium © 2023 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed August 16, 2023.