1. **Background:**

Caprelsa® (vandetanib) is a kinase inhibitor indicated for the treatment of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease. The National Cancer Comprehensive Network (NCCN) recommends use of Caprelsa for the treatment of medullary, follicular, Hürthle cell, and papillary carcinomas. In addition, the National Cancer Comprehensive Network (NCCN) recommends use of Caprelsa as a targeted therapy for Non-Small Cell Lung Cancer in patients with RET rearrangements.

Caprelsa may be used in patients with indolent, asymptomatic or slowly progressing disease after careful consideration of the treatment related risks.

2. **Coverage Criteria:**

A. **Thyroid Carcinoma**

1. **Initial Authorization**

   a. **Caprelsa** will be approved based on **one** of the following:

      (1) Diagnosis of medullary thyroid cancer (MTC)

      -OR-

      (2) **All** of the following criteria:

         (a) **One** of the following diagnosis:

         i. Follicular Carcinoma
         ii. Hürthle Cell Carcinoma
         iii. Papillary Carcinoma
-AND-

(b) **One** of the following:

   i. Unresectable recurrent
   ii. Persistent locoregional disease
   iii. Metastatic disease

-AND-

(c) **One** of the following:

   i. Patient has symptomatic disease
   ii. Patient has progressive disease

-AND-

(d) Disease is refractory to radioactive iodine treatment

Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Caprelsa** will be approved based on the following criterion:

      (1) Patient does not show evidence of progressive disease while on Caprelsa therapy

      Authorization will be issued for 12 months.

B. **Non-Small Cell Lung Cancer**

1. **Initial Authorization**

   a. **Caprelsa** will be approved based on both of the following:

      (1) Diagnosis of Non-Small Cell Lung Cancer (NSCLC)

      -AND-

      (2) Disease is positive for RET gene rearrangement

      Authorization will be issued for 12 months.
2. **Reauthorization**

   a. **Caprelsa** will be approved based on the following criterion:

      (1) Patient does not show evidence of progressive disease while on Caprelsa therapy

      **Authorization will be issued for 12 months.**

3. **References:**


<table>
<thead>
<tr>
<th>Program</th>
<th>Prior Authorization – Caprelsa (vandetanib)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change Control</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Change</td>
</tr>
<tr>
<td>9/19/2013</td>
<td>New guideline</td>
</tr>
<tr>
<td>7/2016</td>
<td>Updated clinical criteria to align with Employer and Individual’s notification policy and updated policy to new template</td>
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<tr>
<td>7/2017</td>
<td>Added criteria for NSCLC. Updated references.</td>
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