Reference number(s)
1854-A

Specialty Guideline Management Cometriq

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Cometriq	cabozantinib

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.

FDA-Approved Indication[1]

Treatment of progressive, metastatic medullary thyroid cancer (MTC).

Compendial Uses[2]

- Follicular and papillary thyroid carcinoma
- Oncocytic/Hurthle Cell thyroid carcinoma
- Non-small cell lung cancer with RET gene arrangements

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

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Documentation

Submission of RET gene rearrangement documentation is necessary to initiate the prior authorization review for the indication of non-small cell lung cancer.

Coverage Criteria

Follicular and Papillary Thyroid Carcinoma[2]

Authorization of 12 months may be granted for treatment of follicular or papillary thyroid carcinoma when all of the following criteria are met:

- The disease is not amenable to radioactive iodine (RAI) therapy.
- The disease has progressed after treatment with lenvatinib or sorafenib.

Oncocytic/Hurthle Cell Thyroid Carcinoma[2]

Authorization of 12 months may be granted for treatment of oncocytic/Hürthle cell thyroid carcinoma when the disease has progressed after treatment with lenvatinib or sorafenib.

Medullary Thyroid Carcinoma[1,2]

Authorization of 12 months may be granted for treatment of medullary thyroid carcinoma.

Non-Small Cell Lung Cancer (NSCLC)[2]

Authorization of 12 months may be granted as a single agent for treatment of recurrent, advanced, or metastatic NSCLC with RET gene rearrangements as subsequent therapy following progression on first-line pralsetinib (Gavreto) or selpercatinib (Retevmo).

Continuation of Therapy

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

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References

1. Cometriq [package insert]. Alameda, CA: Exelixis, Inc.; August 2023.
2. The NCCN Drugs & Biologics Compendium® © 2025 National Comprehensive Cancer Network, Inc. Available at: https://www.nccn.org. Accessed August 8, 2025.