Reference number(s)
2212-A

Specialty Guideline Management Cabometyx

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
Cabometyx	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 Indications[1]

Cabometyx is indicated for the treatment of patients with:

- Advanced renal cell carcinoma (RCC).
- Advanced renal cell carcinoma (RCC), as a first-line treatment in combination with nivolumab.
- Hepatocellular carcinoma (HCC) who have been previously treated with sorafenib.
- Locally advanced or metastatic differentiated thyroid cancer (DTC) that has progressed following prior VEGFR-targeted therapy and who are radioactive iodine-refractory or ineligible (adult and pediatric patients 12 years of age and older).
- Previously treated, unresectable, locally advanced or metastatic, well-differentiated pancreatic neuroendocrine tumors (pNET) (adult and pediatric patients 12 years of age and older).
- Previously treated, unresectable, locally advanced or metastatic, well-differentiated extra-pancreatic neuroendocrine tumors (epNET) (adult and pediatric patients 12 years of age and older).

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Compendial Uses[2]

- Relapsed or stage IV renal cell carcinoma
- Hepatocellular carcinoma as subsequent treatment
- Thryoid carcinoma as a single agent
- Recurrent neuroendocrine and adrenal gland tumors
- Endometrial carcinoma
- Ewing Sarcoma
- Gastrointestinal stromal tumor (GIST)
- Non-small cell lung cancer with RET (rearranged during transfection) gene fusion
- Osteosarcoma
- Soft tissue sarcoma

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

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- Documentation of laboratory report confirming RET gene fusion, where applicable.
- Documentation of laboratory report confirming KIT and PDGFRA mutation, where applicable.

Coverage Criteria

Renal Cell Carcinoma[1,2]

Authorization of 12 months may be granted for treatment of advanced, relapsed, or stage IV renal cell carcinoma (including brain metastases) when used in either of the following settings:

- As a single agent.
- In combination with nivolumab.

Hepatocellular Carcinoma[1,2]

Authorization of 12 months may be granted for subsequent treatment of hepatocellular carcinoma as a single agent.

Thyroid Carcinoma[1,2]

Authorization of 12 months may be granted for treatment of papillary, oncocytic/Hürthle cell, or follicular thyroid carcinoma as a single agent when all of the following criteria are met:

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- Member has locally advanced or metastatic disease.
- Disease has progressed after VEGFR-targeted therapy (e.g., lenvatinib and/or sorafenib).
- Disease is not amenable to radioactive iodine (RAI) therapy.
- Member is at least 12 years old.

Neuroendocrine and Adrenal Gland Tumors[1,2]

Authorization of 12 months may be granted for treatment of recurrent, locoregional advanced, unresectable, or metastatic neuroendocrine and adrenal gland tumors as a single agent.

Endometrial Carcinoma[2]

Authorization of 12 months may be granted for subsequent treatment of recurrent endometrial carcinoma as a single agent.

Ewing Sarcoma[2]

Authorization of 12 months may be granted for subsequent treatment of Ewing sarcoma as a single agent.

Gastrointestinal Stromal Tumor (GIST)[2]

Authorization of 12 months may be granted for treatment of GIST when all of the following criteria are met:

- Member has residual, unresectable, tumor rupture, or recurrent/metastatic disease.
- Disease is imatinib-sensitive KIT and PDGFRA mutation positive (excluding PDGFRA exon 18 mutations).
- Member has failed at least four FDA-approved therapies (e.g., imatininb, sunitinib, regorafenib, ripretinib).
- The requested medication will be used as a single agent.

Non-Small Cell Lung Cancer[2]

Authorization of 12 months may be granted for treatment of recurrent, advanced, or metastatic non-small cell lung cancer with RET gene fusion as a single agent following progression on first-line pralsetinib (Gavreto) or selpercatinib (Retevmo).

Osteosarcoma[2]

Authorization of 12 months may be granted for subsequent treatment of osteosarcoma as a single agent.

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Soft Tissue Sarcoma[2]

Authorization of 12 months may be granted for treatment of alveolar soft part sarcoma (ASPS), epithelioid hemangioendothelioma, or extraskeletal myxoid chondrosarcoma as a single agent.

Continuation of Therapy

GIST[2]

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for GIST when there is no evidence of unacceptable toxicity while on the current regimen.

All Other Indications

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

References

1. Cabometyx [package insert]. Alameda, CA: Exelixis, Inc.; October 2025.
2. The NCCN Drugs & Biologics Compendium® © 2026 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed May 4, 2026.

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