



Prior Authorization Approval Criteria

Caprelsa (vandetanib)

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|---|---|
| Generic name: | vandetanib |
| Brand name: | Caprelsa |
| Medication class: | kinase inhibitor; anti-neoplastic agent |
| FDA-approved uses: | Treatment of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease |
| Available dosage forms: | 100 and 300mg tablet |
| Usual dose: | 300mg once daily. 200mg once daily in patients with moderate to severe renal impairment |
| Approximate monthly cost: (based on AWP 2011) | \$11,880 per month |

Criteria for use (*bullet points below are all inclusive unless otherwise noted*):

- The indicated diagnosis (including any applicable labs and /or tests) and medication usage must be supported by documentation from the patient's medical records.
- Clinically diagnosed with symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease
- Must provide recent CrCl or scr and patient weight
- Approval will be for a period of 6 months

Criteria for continuation of therapy:

- Disease has not progressed
- Patient is tolerating treatment

Caution:

- Prolonged QT interval
- Steven-Johnson syndrome
- Interstitial lung disease

Contraindication:

- Congenital long QT syndrome

Not approved if:

- Does not meet above criteria

FCHP Pharmacy and Therapeutics Committee approval: _____

Date: _____

Adopted: 09/07/2011