



## PRIOR AUTHORIZATION POLICY

**POLICY:** Oncology – Capecitabine Prior Authorization

- Xeloda® (capecitabine tablets – Genentech, generic)

**REVIEW DATE:** 07/27/2022; selected revision 09/14/2022

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### OVERVIEW

Capecitabine, a nucleoside metabolic inhibitor with antineoplastic activity, is indicated for the following uses:<sup>1</sup>

- **Breast cancer**, treatment of advanced or metastatic disease:
  - In combination with docetaxel after disease progression on prior anthracycline-containing chemotherapy.
  - As a single agent if an anthracycline- or taxane-containing chemotherapy is not indicated.
- **Colorectal cancer:**
  - Adjuvant treatment of patients with Stage III colon cancer as a single agent or as a component of a combination chemotherapy regimen.
  - Perioperative treatment of adults with locally advanced rectal cancer as a component of chemoradiotherapy.
  - Treatment of patients with unresectable or metastatic colorectal cancer as a single agent or as a component of a combination chemotherapy regimen.
- **Gastric, esophageal, or gastroesophageal junction cancer**, treatment of adults with:
  - Unresectable or metastatic disease as a component of a combination chemotherapy regimen.
  - HER2-overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma who have not received prior treatment for metastatic disease as a component of a combination regimen.
- **Pancreatic Cancer**, adjuvant treatment of adults with pancreatic adenocarcinoma as a component of a combination chemotherapy regimen.

### Guidelines

The National Comprehensive Cancer Network (NCCN) Compendium recommends use of capecitabine for the indications listed in the FDA-Approved Indications and Other Uses with Supportive Evidence sections.<sup>2</sup>

### POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of capecitabine. All approvals are provided for the duration noted below.

**Automation:** None.

### RECOMMENDED AUTHORIZATION CRITERIA

Coverage of capecitabine is recommended in those who meet one of the following criteria:

#### FDA-Approved Indications

1. **Breast Cancer.** Approve for 1 year if the patient is  $\geq 18$  years of age.
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2. **Colon Cancer.** Approve for 1 year if the patient is  $\geq 18$  years of age.
3. **Esophageal and Esophagogastric Junction Cancers.** Approve for 1 year if the patient is  $\geq 18$  years of age.
4. **Gastric Cancer.** Approve for 1 year if the patient is  $\geq 18$  years of age.
5. **Pancreatic Adenocarcinoma.** Approve for 1 year if the patient is  $\geq 18$  years of age.

#### **Other Uses with Supportive Evidence**

6. **Ampullary Adenocarcinoma.** Approve for 1 year if the patient is  $\geq 18$  years of age.
7. **Anal Carcinoma.** Approve for 1 year if the patient is  $\geq 18$  years of age.
8. **Central Nervous System Cancers.** Approve for 1 year if the patient is  $\geq 18$  years of age.
9. **Gestational Trophoblastic Neoplasia.** Approve for 1 year if the patient is  $\geq 18$  years of age.
10. **Head and Neck Cancers.** Approve for 1 year if the patient is  $\geq 18$  years of age.
11. **Hepatobiliary Cancers.** Approve for 1 year if the patient is  $\geq 18$  years of age.
12. **Neuroendocrine and Adrenal Tumors.** Approve for 1 year if the patient is  $\geq 18$  years of age.
13. **Occult Primary.** Approve for 1 year if the patient is  $\geq 18$  years of age.
14. **Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer.** Approve for 1 year if the patient is  $\geq 18$  years of age.
15. **Penile Cancer.** Approve for 1 year if the patient is  $\geq 18$  years of age.
16. **Rectal Cancer.** Approve for 1 year if the patient is  $\geq 18$  years of age.
17. **Small Bowel Adenocarcinoma.** Approve for 1 year if the patient is  $\geq 18$  years of age.
18. **Squamous Cell Skin Cancer.** Approve for 1 year if the patient is  $\geq 18$  years of age.
19. **Thymomas and Thymic Carcinomas.** Approve for 1 year if the patient is  $\geq 18$  years of age.

#### **CONDITIONS NOT RECOMMENDED FOR APPROVAL**

Coverage of capecitabine is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

#### **REFERENCES**

1. Xeloda<sup>®</sup> tablets [prescribing information]. South San Francisco, CA: Genentech; December 2022.
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2. The NCCN Drugs & Biologics Compendium. © 2022 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on July 25, 2022. Search terms: capecitabine.

## HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	07/14/2021
Selected Revision	For all approval conditions, the approval duration was changed from 3 years to 1 year.	06/22/2022
Annual Revision	The title of the policy changed to add “with Step Therapy.” <b>Ampullary Adenocarcinoma:</b> Condition of approval and criteria were added.	07/27/2022
Selected Revision	The name of the policy was changed from Oncology – Capecitabine PA with Step Therapy to Oncology – Capecitabine PA. For all approval conditions, the requirement for trial of generic capecitabine and the criterion that the patient cannot take generic capecitabine due to a formulation difference in the inactive ingredient between the brand and bioequivalent generic product, which, per the prescriber, would result in a significant allergy or serious adverse reaction was removed. The documentation requirement was also removed. For all approval conditions, the requirement that the patient is $\geq 18$ years old was added.	09/14/2022
Update	<b>12/20/2022:</b> The overview section was updated to include new FDA approved indications of gastric, esophageal, or gastroesophageal junction cancer and of pancreatic cancer; breast and colorectal indications were also modified as per updated labeling. The following indications were moved from the Other Uses with Supportive Evidence into FDA approved indications section: Esophageal and Esophagogastric Junction Cancers, Gastric Cancer, and Pancreatic Adenocarcinoma.	--