VENTURA COUNTY
HEALTH CARE PLAN

PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Oral) – Truqap Prior Authorization Policy
- Truqap® (capivasertib tablets – AstraZeneca)

REVIEW DATE: 07/08/2026

OVERVIEW

Truqap, a kinase inhibitor, is indicated for the treatment of the following:[1]

- **Breast cancer**, locally advanced or metastatic, in combination with fulvestrant in adults with hormone receptor-positive (HR+), human epidermal growth factor receptor 2 (HER2)-negative with one or more phosphatidylinositol 3-kinase (*PIK3CA*)/serine/threonine protein kinase 1 (*AKT1*)/phosphatase and tensin homolog (*PTEN*)-alterations as detected by an FDA-approved test following progression on at least one endocrine-based regimen in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy.
- **Prostate cancer,** in combination with abiraterone and prednisone for adults with metastatic androgen pathway modulation-naïve or sensitive (mAPMN/S) disease that is *PTEN*-deficient as detected by an FDA-authorized test.

Guidelines

Truqap is discussed in guidelines from the National Comprehensive Cancer Network (NCCN):

- **Breast Cancer**: NCCN guidelines (version 5.2026 – July 7, 2026) recommend Truqap + fulvestrant for patients with HR+/HER2-negative disease with *PIK3CA* or *AKT1* activating mutations or *PTEN* inactivating mutations and genomic changes (e.g. deletion) as a "Preferred Regimen" for second or subsequent-line therapy in selected patients (category 1) after disease progression or recurrence after a prior line of endocrine therapy and a cyclin-dependent kinase (CDK) 4/6 inhibitor.[2]
- **Prostate Cancer**: NCCN guidelines (version 5.2026 – January 23, 2026) do not include Truqap yet.[3] The guidelines recommend androgen deprivation therapy ± docetaxel and one of the following: abiraterone, Nubeqa® (darolutamide tablets), Erleada® (apalutamide tablets), and Xtandi® (enzalutamide capsules and tablets) for metastatic castration sensitive prostate cancer. Additionally, Zejula® (niraparib tablets) + abiraterone is recommended for breast cancer (BRCA)-2 mutation.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Truqap. All approvals are provided for the duration noted below. In the clinical criteria, as appropriate, an asterisk (*) is noted next to the specified gender. In this context, the specified gender is defined as follows: a female is defined as an individual with the biological traits of a female, regardless of the individual's gender identity or gender expression; a male is defined as an individual with the biological traits of a male, regardless of the individual's gender identity or gender expression.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

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

FDA-Approved Indications

1. **Breast Cancer**. Approve for 1 year if the patient meets ALL of the following (A, B, C, D, E, F and G):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has advanced or metastatic disease; AND
   - **C)** Patient has hormone receptor-positive (HR+) disease; AND
   - **D)** Patient has human epidermal growth factor receptor 2 (*HER2*)-negative disease; AND
   - **E)** Patient has at least one *PIK3CA*, *AKT1*, or *PTEN*-alteration or inactivating mutations and genomic changes; AND
   - **F)** Patient meets ONE of the following (i or ii):
     - **i.** Patient meets BOTH of the following (a and b):
       - **a)** Patient has had progression with at least one endocrine-based regimen in the metastatic setting; AND
         Note: Examples of endocrine-based therapy include anastrozole, exemestane, and letrozole.
       - **b)** Patient has had progression with at least one cyclin-dependent kinase (CDK) 4/6 inhibitor in the metastatic setting; OR
         Note: Examples of CDK4/6 inhibitor include: Ibrance (palbociclib tablets or capsules), Verzenio (abemaciclib tablets), Kisqali (ribociclib tablets), Kisqali Femara Co-Pack (ribociclib and letrozole tablets).
     - **ii.** Patient has recurrence on or within 12 months of completing adjuvant endocrine therapy; AND
   - **G)** Patient meets ONE of the following (i or ii):
     - **i.** Patient is a male* or postmenopausal female*; OR
     - **ii.** Patient is a pre/perimenopausal female* and meets ONE of the following (a or b):
       - **a)** Patient is receiving ovarian suppression with a gonadotropin-releasing hormone (GnRH) agonist; OR
         Note: Examples of a GnRH agonist include leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous injection).
       - **b)** Patient has had surgical bilateral oophorectomy or ovarian irradiation.

   * Refer to Policy Statement

2. **Prostate Cancer**. Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient meets ONE of the following (i or ii):
     - **i.** Patient has metastatic androgen pathway modulation-naïve disease; OR
       Note: This includes patients who have not received androgen pathway modulation therapy.
     - **ii.** Patient has metastatic androgen pathway modulation-sensitive disease; AND
       Note: This includes metastatic hormone sensitive prostate cancer or metastatic castration sensitive prostate cancer.
   - **C)** Patient has *PTEN*-deficient disease; AND
   - **D)** The medication will be used in combination with abiraterone and prednisone.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Truqap 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. Truqap® tablets [prescribing information]. Wilmington, DE: AstraZeneca; June 2026.
2. The NCCN Breast Cancer Clinical Practice Guidelines in Oncology (version 5.2026 – July 7, 2026). © 2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on July 8, 2026.
3. The NCCN Prostate Cancer Clinical Practice Guidelines in Oncology (version 5.2026 – January 23, 2026). © 2026 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on July 6, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	07/10/2024
Annual Revision	No criteria changes.	07/02/2025
Annual Revision	The name of the policy was changed to as listed. Previously, it was called Oncology – Truqap Prior Authorization. **Breast Cancer:** The wording "locally" was removed from the criterion, "patient has locally advanced or metastatic disease." The wording, "inactivating mutations and genomic changes" was added to *PTEN* alterations. The requirement that the patient is a man, postmenopausal female, or a pre/perimenopausal female who is receiving ovarian suppression with a gonadotropin-releasing hormone (GnRH) agonist, has had surgical bilateral oophorectomy, or has had ovarian irradiation was added. A Note was added with examples of a GnRH agonist. **Prostate Cancer**: This was added as a new condition for approval.	07/08/2026