I. Medication Description

Cabazitaxel is a potent microtubule stabilizer. Cabazitaxel binds to tubulin and promotes its assembly into microtubules, while simultaneously inhibiting disassembly. This leads to the stabilization of microtubules, which results in the inhibition of mitotic and interphase cellular functions.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

III. Policy

Coverage of Jevtana is available when the following criteria have been met:

- Member is at least 18 years of age AND
- The medication is prescribed by a hematologist/oncologist AND
- The requested use is supported by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines (NCCN Guidelines®) and/or NCCN Drugs & Biologics Compendium (NCCN Compendium®) with a recommendation of category level 1 or 2A.

IV. Quantity Limitations

Coverage will be provided for doses up to 25mg/m² IV once every 3 weeks

V. Coverage Duration

Coverage is provided for 6 months and may be renewed.

VI. Coverage Renewal Criteria

Coverage can be renewed based upon the following criteria:

- Stabilization of disease or in absence of disease progression AND
- Absence of unacceptable toxicity from the drug

VII. Billing/Coding Information

- J9043: 1 billable unit = 1mg
Drug Therapy Guidelines  Jejtana® (cabazitaxel)  Last Review Date: 6/2019

- Pertinent indications
  - Malignant neoplasm of prostate: C61
  - Personal history of malignant neoplasm of prostate: Z85.46

VIII. Summary of Policy Changes

- 3/1/11: new policy
- 6/15/12: drug-specific J code referenced in policy
- 3/15/13: pertinent indications added, related guidelines added
- 3/15/14: require oncologist prescribing for coverage
- 3/15/15: no policy changes
- 7/1/15: formulary distinctions made
- 9/15/15: no policy changes
- 7/19/16: no policy changes
- 6/21/17: coverage criteria updated to allow use as supported by current NCCN guidelines
- 6/15/18: no policy changes
- 8/15/19: updated quantity limitations

IX. References


*These guidelines are not applicable to benefits covered under Medicare Advantage. Medicare Advantage benefit coverage requests are reviewed in accordance with the guidance set forth in Chapter 15 Section 50 of the Centers for Medicare & Medicaid Services Medicare Benefit Policy Manual.

The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.