PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Tabrecta Prior Authorization Policy
- Tabrecta® (capmatinib tablets – Novartis)

REVIEW DATE: 02/11/2026

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Tabrecta, a kinase inhibitor, is indicated for the treatment of metastatic **non-small cell lung cancer (NSCLC)** in adults whose tumors have a mutation that leads to mesenchymal-epithelial transition (*MET*) exon 14 skipping as detected by an FDA-approved test.[1]

Guidelines

The National Comprehensive Cancer Network (NCCN) NSCLC guidelines (version 3.2026 – December 24, 2025) recommend Tabrecta (category 2A) as a "Preferred" first-line or subsequent line treatment option for patients with advanced or metastatic NSCLC who are positive for *MET* exon 14 skipping mutations or high-level *MET* amplification.[2]

POLICY STATEMENT

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

- **Tabrecta® (capmatinib tablets - Novartis)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Non-Small Cell Lung Cancer.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has advanced or metastatic disease; AND
   - **C)** Patient meets ONE of the following (i or ii):
     - **i.** Patient has mesenchymal epithelial transition (*MET*) exon 14 skipping mutations; OR
     - **ii.** Patient has high-level *MET* amplification.

CONDITIONS NOT COVERED

- **Tabrecta® (capmatinib tablets - Novartis)**

is(are) considered experimental, investigational, or unproven for ANY other use(s); criteria will be updated as new published data are available.

REFERENCES

1. Tabrecta® tablets [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2024.
2. The NCCN Non-Small Cell Lung Cancer Clinical Practice Guidelines in Oncology (version 3.2026 – December 24, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org/. Accessed on February 7, 2026.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Non-Small Cell Lung Cancer:** Criterion that patient has metastatic disease was changed to include advanced; revised to read: Patient has advanced or metastatic disease.	02/01/2023
Annual Revision	No criteria changes.	02/07/2024
Annual Revision	No criteria changes.	02/19/2025
Annual Revision	**Non-Small Cell Lung Cancer:** In reference to mesenchymal epithelial transition (MET) exon 14 skipping mutations and high-level MET amplification, the requirement that the mutation was detected by an approved test was deleted.	02/11/2026