

Medical Policy Manual **Approved Rev: Do Not Implement until 4/2/26**

Cabazitaxel (Jevtana®); Cabazitaxel

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

POLICY

INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

Jevtana is indicated in combination with prednisone for the treatment of patients with metastatic castration-resistant prostate cancer previously treated with a docetaxel-containing treatment regimen.

Compendial Uses

- Subsequent treatment for castration-resistant distant metastatic disease previously treated with a docetaxel-based regimen or in patients who are not candidates for, or are intolerant of docetaxel
- Subsequent treatment for castration-resistant distant metastatic disease previously treated with novel hormone therapy (e.g., enzalutamide [Xtandi] or abiraterone [Zytiga])

All other indications are considered experimental/investigational and not medically necessary.

COVERAGE CRITERIA

Metastatic Castration-Resistant Prostate Cancer (CRPC)

Authorization of 6 months may be granted for the treatment of metastatic castration-resistant prostate cancer when previously treated with any of the following:

- A docetaxel-containing regimen or in **members** who are not candidates for or who are intolerant to docetaxel.
- Novel hormone therapy (e.g., enzalutamide [Xtandi], abiraterone [Zytiga]).

Authorization of 6 months may be granted for the treatment of metastatic castration-resistant small cell/neuroendocrine prostate cancer.

CONTINUATION OF THERAPY

Authorization of 6 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

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APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS

BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

1. Jevtana [package insert]. **Morristown, NJ: sanofi-aventis U.S. LLC; May 2025.**
2. Cabazitaxel [package insert]. **Durham, NC: Accord Healthcare Inc.; October 2021.**
3. The NCCN Drugs & Biologics Compendium® © 2025 National Comprehensive Cancer Network, Inc. <http://www.nccn.org>. Accessed August 13, 2025.

EFFECTIVE DATE 4/2/2026

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