

PHARMACY COVERAGE GUIDELINE

GAVRETO™ (pralsetinib) Generic Equivalent (if available)

This Pharmacy Coverage Guideline (PCG):

- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively “Service”) is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider’s judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member’s benefit plan; and
- Is subject to change as new information becomes available.

Scope

- This PCG applies to Commercial and Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

Instructions & Guidance

- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The “Criteria” section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member’s benefit plan.
- The “Description” section describes the Service.
- The “Definition” section defines certain words, terms or items within the policy and may include tables and charts.
- The “Resources” section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at www.azblue.com/pharmacy. You must fully complete the [request form](#) and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to Pharmacyprecert@azblue.com.

Criteria:

- **Criteria for initial therapy:** Gavreto (pralsetinib) and/or generic equivalent (if available) is considered **medically necessary** and will be approved when **ALL** of the following criteria are met:
 1. Prescriber is a physician specializing in the patient’s diagnosis or is in consultation with an Oncologist
 2. Individual has a confirmed diagnosis of **ONE** of the following:
 - a. Individual is 18 years of age or older with metastatic, rearranged during transfection (**RET**) **fusion-positive** non-small cell lung cancer (**NSCLC**)
 - b. Individual is 12 years of age or older with advanced or metastatic **RET fusion-positive, non-medullary thyroid cancer** who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate)

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- c. Other request for a specific oncologic direct treatment use that is found and listed in the National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1 and 2A
3. Individual has completed **ALL** the following **baseline tests** before initiation of treatment and will have continued monitoring as clinically appropriate:
 - a. Negative pregnancy test in a woman of childbearing potential
 - b. Blood pressure is within normal limits prior to initiating
 - c. Liver tests for AST and ALT
 - d. Individual has an Eastern Cooperative Oncology Group (ECOG) Performance Status score of 0-2
4. **If available:** Individual has failure after adequate trial, contraindication per FDA label or intolerance, or is not a candidate for a **generic equivalent** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] ([see Definitions section](#))
5. Individual does not have severe renal impairment (CrCl of less than 15 mL/min)

Initial approval duration: 6 months

➤ **Criteria for continuation of coverage (renewal request):** Gavreto (pralsetinib) and/or generic equivalent (if available) is considered **medically necessary** and will be approved when **ALL** of the following criteria are met (**samples are not considered for continuation of therapy**):

1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with an Oncologist
2. Individual has documentation of positive clinical response to therapy defined as there is no evidence of disease progression and there is no evidence of unacceptable toxicity
3. Individual has been adherent with the medication
4. **If available:** Individual has failure after adequate trial, contraindication per FDA label or intolerance, or is not a candidate for a **generic equivalent** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] ([see Definitions section](#))
5. Individual is using at least 100 mg daily
6. Individual has not developed any significant adverse drug effects that may exclude continued use such as:
 - a. Interstitial lung disease/pneumonitis that is severe to life-threatening or has recurred after interruption and dose reduction
 - b. Hypertension that is life-threatening or is uncontrolled despite medical therapy
 - c. Hepatotoxicity that has recurred after interruption and dose reduction
 - d. Severe or life-threatening hemorrhagic events
 - e. Severe growth abnormalities in a pediatric patient with open growth plates
 - f. Other life-threatening adverse reactions that recur

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7. Individual does not have severe renal impairment (CrCl of less than 15 mL/min)

Renewal duration: 12 months

➤ Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of Non-Cancer Medications**
2. **Off-Label Use of Cancer Medications**

Description:

Gavreto (pralsetinib) is a kinase inhibitor indicated for the treatment of adult patients with metastatic rearranged during transfection (RET) fusion-positive non-small cell lung cancer (NSCLC) as detected by an FDA approved test. It is also indicated for the treatment of adult and pediatric patients 12 years of age and older with advanced or metastatic RET-mutant medullary thyroid cancer (MTC) who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate). This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for these indications may be contingent upon verification and description of clinical benefit in confirmatory trial(s).

Definitions:

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting
[MedWatch Forms for FDA Safety Reporting | FDA](#)

ECOG Performance status:

Eastern Co-operative Oncology Group (ECOG) Performance Status	
Grade	ECOG description
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours
3	Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours
4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
5	Dead

Oken, M.M., Creech, R.H., Tormey, D.C., Horton, J., Davis, T.E., McFadden, E.T., Carbone, P.P.: Toxicity And Response Criteria Of The Eastern Cooperative Oncology Group. Am J Clin Oncol 5:649-655, 1982

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NCCN recommendation definitions:

Category 1:

Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

Category 2A:

Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.

Category 2B:

Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.

Category 3:

Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate

Common Terminology Criteria for Adverse Events (CTCAE) Version 4.03:

Grade 1	Mild; asymptomatic or mild symptoms; clinical or diagnostic observations only; intervention not indicated
Grade 2	Moderate; minimal, local or noninvasive intervention indicated; limiting age-appropriate instrumental ADL*
Grade 3	Severe or medically significant but not immediately life-threatening; hospitalization or prolongation of hospitalization indicated; disabling; limiting self-care ADL**
Grade 4	Life-threatening consequences: urgent intervention indicated
Grade 5	Death related to AE
U.S. department of Health and Human Services, National Institutes of Health, and National Cancer Institute	

Resources:

Gavreto (pralsetinib) product information, revised by manufacturer Rigel Pharmaceuticals, Inc. 06-2024. Available at DailyMed <http://dailymed.nlm.nih.gov>. Accessed July 24, 2025.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Non-Small Cell Lung Cancer Version 08.2025 – Updated August 15, 2025. Available at <https://www.nccn.org>. Accessed October 07, 2025.

National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®): Thyroid Carcinoma Version 01.2025 – Updated March 27, 2025. Available at <https://www.nccn.org>. Accessed October 08, 2025.

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.