



UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1429-1
Program	Prior Authorization/Notification
Medication	Truqap™ (capivasertib)
P&T Approval Date	1/2024
Effective Date	4/1/2024

1. Background:

Truqap (capivasertib) is a kinase inhibitor indicated, in combination with fulvestrant, for the treatment of adult patients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, locally advanced or metastatic breast cancer with one or more PIK3CA/AKT1/PTEN-alterations following progression on at least one endocrine-based regimen in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy.

2. Coverage Criteria^a:

A. Patients less than 19 years of age

1. **Truqap** will be approved based on the following criterion:

- a. Patient is less than 19 years of age

Authorization will be issued for 12 months.

B. Breast Cancer

1. **Initial Authorization**

a. **Truqap** will be approved based on **all** of the following criteria:

- (1) Diagnosis of breast cancer

-AND-

- (2) **One** of the following:

- (a) Locally advanced
- (b) Metastatic

-AND-

- (3) Disease is hormone receptor (HR)-positive

-AND-

- (4) Disease is human epidermal growth factor receptor 2 (HER2)-negative

-AND-

(5) Presence of one or more PIK3CA/AKT1/PTEN-alterations

-AND-

(6) **One** of the following:

- (a) Has progressed on at least one endocrine-based regimen in the metastatic setting (e.g., anastrozole, letrozole, exemestane, tamoxifen)
- (b) Recurrence on or within 12 months of completing adjuvant therapy

-AND-

(7) Used in combination with fulvestrant

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Truqap** will be approved based on **all** of the following criteria:

(1) Patient does not show evidence of progressive disease while on Truqap therapy

-AND-

(2) Used in combination with fulvestrant

Authorization will be issued for 12 months.

C. **NCCN Recommended Regimens**

1. The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B

Authorization will be issued for 12 months.

^a State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. **Additional Clinical Rules:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. **References:**

1. Truqap [package insert]. Wilmington, DE: Astra Zeneca; November 2023.



Program	Prior Authorization/Notification - Truqap™ (capivasertib)
Change Control	
1/2024	New program