Cabazitaxel:
Jevtana®; Cabazitaxel§
(Intravenous)

-E-

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I. Length of Authorization

Coverage will be provided for 6 months and may be renewed.

II. Dosing Limits

Max Units (per dose and over time) [HCPCS Unit]:

- Jevtana [J9043]: 60 billable units per 21 days
- Cabazitaxel [J9064]: 50 mg per 21 days

III. Initial Approval Criteria [1,2]

Coverage is provided in the following conditions:

- Patient is at least 18 years of age; **AND**

Universal Criteria [1-4]

- Must be used in combination with a steroid (e.g., prednisone or dexamethasone); **AND**
- Patient does not have severe hepatic impairment (e.g., total bilirubin > 3 times the upper limit of normal); **AND**

Prostate Cancer † ‡ [1-4,1e,4e,6e]

- Patient has castration-resistant metastatic disease; **AND**
  - Used as a single agent †; **AND**
    - Patient must have been previously treated with docetaxel unless not a candidate for or intolerant to docetaxel; **OR**
  - Used in combination with carboplatin ‡; **AND**
    - Used for fit patients with aggressive variant disease (i.e., visceral metastases, low prostate-specific antigen and bulky disease, high LDH, high CEA, lytic bone

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metastases, neuroendocrine prostate cancer histology) or unfavorable genomics (i.e., defects in at least two of the following: PTEN, TP53, and RB1); **AND**

- Disease has progressed on prior docetaxel and patient has not received prior novel hormone therapy; **OR**
- Disease has progressed on prior novel hormone therapy and patient has not received prior docetaxel; **OR**
- Disease has progressed on prior docetaxel and prior novel hormone therapy

Preferred therapies and recommendations are determined by review of clinical evidence. NCCN category of recommendation is taken into account as a component of this review. Regimens deemed equally efficacious (i.e., those having the same NCCN categorization) are considered to be therapeutically equivalent.

Enhanced Oncology Value (EOV) Program – Redacted indications
Uses not listed above have inadequate data to support efficacy and are excluded from coverage. Other treatment options including, but are not limited to, the following may be appropriate: radiation therapy, surgery, traditional chemotherapy (e.g., platinum, taxane), compassionate use/expanded access programs, clinical trials, supportive care, integrative and complementary therapies.

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); Φ Orphan Drug

IV. Renewal Criteria [1,2]

Coverage can be renewed based upon the following criteria:

- Patient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Disease response with treatment as defined by lack of disease progression, improvement in tumor size and/or improvement in patient symptoms; **AND**
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: bone marrow suppression (neutropenia, anemia, thrombocytopenia, and/or pancytopenia), severe hypersensitivity reactions, gastrointestinal adverse reactions (severe diarrhea, nausea, vomiting), urinary disorders including severe hemorrhagic cystitis, renal failure, hepatic impairment, respiratory disorders (interstitial pneumonia/pneumonitis, interstitial lung disease, acute respiratory distress syndrome), etc.

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V. Dosage/Administration [1,2]

Indication	Dose
Prostate Cancer	**Jevtana** Administer 20-25 mg/m², intravenously, every 3 weeks in combination with an oral corticosteroid **Cabazitaxel** Administer 20 mg/m², intravenously, every 3 weeks in combination with an oral corticosteroid

VI. Billing Code/Availability Information

HCPCS Code(s):

- J9043 – Injection, cabazitaxel, 1 mg: 1 billable unit = 1 mg *(Jevtana ONLY)*
- J9064 – Injection, cabazitaxel (sandoz), not therapeutically equivalent to J9043, 1 mg; 1 billable unit = 1 mg
- J9999 – Not otherwise classified, antineoplastic drugs *(Applicable to other unclassified 505(b)(2) NDA for cabazitaxel not otherwise listed)* **§**

NDC(s):

- Jevtana 60 mg/1.5mL solution for injection kit in a single-dose vial: 00024-5824-xx
- Cabazitaxel (Sandoz) 45 mg/4.5 mL solution for injection in a multiple-dose vial: 00781-3186-xx **§**
- Cabazitaxel (Sandoz) 60 mg/6 mL solution for injection in a multiple-dose vial: 00781-3193-xx **§**

§ *Designated products approved by the FDA as a 505(b)(2) NDA of the innovator product. These products are not rated as therapeutically equivalent to their reference listed drug in the Food and Drug Administration's (FDA) Orange Book and are therefore considered single source products based on the statutory definition of "single source drug" in section 1847A(c)(6) of the Act. For a complete list of all approved 505(b)(2) NDA products please reference the latest edition of the Orange Book:*

Approved Drug Products with Therapeutic Equivalence Evaluations | Orange Book | FDA

VII. References (STANDARD)

1. Jevtana [package insert]. Bridgewater, NJ; Sanofi-Aventis U.S. LLC; May 2025. Accessed June 2025.
2. Cabazitaxel [package insert]. Princeton, NJ; Sandoz Inc.; January 2023. Accessed March 2025.
3. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for cabazitaxel. National Comprehensive Cancer Network, 2025. The NCCN Compendium® is a derivative work of the NCCN Guidelines®. NATIONAL COMPREHENSIVE CANCER NETWORK®, NCCN®, and NCCN GUIDELINES® are trademarks owned by the National Comprehensive Cancer Network, Inc. To view the most recent and complete version of the Compendium, go online to NCCN.org. Accessed June 2025.
4. Referenced with permission from the NCCN Drugs & Biologics Compendium (NCCN Compendium®) for Prostate Cancer, Version 2.2025. National Comprehensive Cancer Network,

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VIII. References (ENHANCED)

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2e. Scher H, Fizazi K, Saad F, et al. Increased Survival with Enzalutamide in Prostate Cancer after Chemotherapy. N Engl J Med 2012; 367:1187-1197.

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Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
C61	Malignant neoplasm of prostate
C7A.1	Malignant poorly differentiated neuroendocrine tumors
C7A.8	Other malignant neuroendocrine tumors
Z85.46	Personal history of malignant neoplasm of prostate

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

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Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdictio	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC

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