

Applicable Drugs: Truqap (capivasertib)

Preferred: N/A

Non-preferred: N/A

Date of Origin: 8/25/2024

Date Last Reviewed / Revised: 2/20/2026

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I-V are met)

- I. Documentation of the following FDA-approved diagnoses (A) AND must meet all criteria listed under the applicable diagnosis:
FDA-Approved Indication(s)
 - A. Breast Cancer
 - i. Documented diagnosis of hormone receptor (HR) positive, human epidermal growth factor receptor 2 (HER-2) negative, locally advanced or metastatic breast cancer.
 - ii. One or more documented phosphatidylinositol 3-kinase (PIK3CA), serine/threonine protein kinase (AKT1), or phosphatase and tensin homolog (PTEN) alterations as detected by an FDA-approved test.
 - iii. Used in combination with fulvestrant.
 - iv. Documentation of progression on at least one endocrine-based therapy (e.g., anastrozole, letrozole, exemestane, tamoxifen) including a CDK4/6 inhibitor (e.g., palbociclib [Ibrance] ribociclib [Kisqali], abemaciclib [Verzenio]) in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy.
- II. Minimum age requirement: 18 years old.
- III. Treatment must be prescribed by or in consultation with an oncologist or hematologist.
- IV. Request is for a medication with the appropriate FDA labeling, or its use is supported by current National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1 or 2A.
- V. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have documented treatment failure or contraindication to the preferred product(s).

EXCLUSION CRITERIA

- N/A

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- 160mg or 200mg tablet: 64 tablets/28 days

APPROVAL LENGTH

- **Authorization:** 6 months
- **Re-Authorization:** 6 months with an updated letter of medical necessity or progress notes showing current medical necessity criteria are met and does not show evidence of progressive disease.

APPENDIX

N/A

REFERENCES

1. Truqap. Prescribing information. Astra Zeneca. 2025. Accessed February 20, 2026. https://drd9vr9dh9yh09.cloudfront.net/50fd68b9-106b-4550-b5d0-12b045f8b184/841065f2-fcba-4795-b92a-3afc2ba47325/841065f2-fcba-4795-b92a-3afc2ba47325_viewable_rendition__v.pdf
2. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Breast Cancer. Version 1.2026. Updated January 16, 2026. Accessed February 20, 2026. www.nccn.org/professionals/physician_gls/pdf.breast.pdf
3. Turner NC, Oliveira M, Howell SJ, et al. Capivasertib in hormone receptor-positive advanced breast cancer. *N Engl J Med*. 2023;388(22):2058-2070. doi: 10.1056/NEJMoa2214131

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.