Clinical Policy: Panitumumab (Vectibix)

Reference Number: CP.PHAR.321
Effective Date: 03.01.17
Last Review Date: 11.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Panitumumab (Vectibix®) is an epidermal growth factor receptor (EGFR) antagonist.

FDA Approved Indication(s)

Vectibix is indicated:

- For the treatment of adult patients with wild-type *RAS* (defined as wild-type in both *KRAS* and *NRAS* as determined by an FDA-approved test) metastatic colorectal cancer (mCRC):
  - In combination with FOLFOX for first-line treatment
  - As monotherapy following disease progression after prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy
- In combination with sotorasib, for the treatment of adult patients with *KRAS* G12C-mutated mCRC, as determined by an FDA-approved test, who have received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy.

Limitation(s) of use: Vectibix is not indicated for the treatment of patients with *RAS*-mutant mCRC unless used in combination with sotorasib in *KRAS* G12C-mutated mCRC. Vectibix is not indicated for the treatment of patients with mCRC for whom *RAS* mutation status is unknown.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Vectibix is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Colorectal Cancer (must meet all)**:**

1. Diagnosis of advanced, recurrent, or metastatic CRC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is one of the following (a, b, c, d, or e):
   a. *KRAS/NRAS/BRAF* wild-type (i.e., no mutations in *KRAS*, *NRAS*, or *BRAF* genes);
   b. *BRAF* V600E mutation positive;
   c. *KRAS* G12C mutation positive;
   d. Deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H);

e. Polymerase epsilon/delta (POLE/POLD1) mutation positive with ultra-hypermutated phenotype (e.g., tumor mutation burden [TMB] > 50 mut/Mb);

5. Prescribed in one of the following ways (a, b, c, d, or e)*:
   a. As a single agent;
   b. In combination with FOLFOX, CapeOX, or FOLFIRI;
   c. In combination with irinotecan following prior therapy;
   d. In combination with Braftovi® with or without FOLFOX;
   e. In combination with Lumakras® or Krazati® following prior therapy;

   **Prior authorization may be required.*
6. For colon cancer that is *KRAS/NRAS/BRAF* wild-type with unresectable synchronous liver and/or lung metastases or unresectable metachronous metastases: Colon cancer is left-sided only (*see Appendix D*);
7. For dMMR/MSI-H or POLE/POLD1 mutation positive cancer: Member is ineligible for or has progressed on checkpoint inhibitor immunotherapy (*see Appendix B*);*

   **Prior authorization may be required.*
8. Request meets one of the following (a or b):*
   a. Dose does not exceed 6 mg/kg every 14 days;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. NCCN Recommended Uses (off-label) (must meet all)**:**

1. Diagnosis of one of the following (a or b):
   a. One of the following appendiceal neoplasms and cancers (i, ii, or iii):
      i. Appendiceal adenocarcinoma;
      ii. Goblet cell adenocarcinoma;
      iii. Undifferentiated carcinoma not otherwise specified;
   b. Small bowel adenocarcinoma, that is advanced or metastatic;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is one of the following (a, b, or c):
   a. *KRAS/NRAS/BRAF* wild-type (i.e., no mutations in *KRAS*, *NRAS*, or *BRAF* genes);
   b. *BRAF* V600E mutation positive;
   c. *KRAS* G12C mutation positive;
5. Prescribed in one of the following ways (a, b, c, d, or e)*:
   a. As a single agent;
   b. In combination with FOLFOX, CapeOX, or FOLFIRI;
   c. In combination with irinotecan following prior therapy;
   d. If *BRAF* V600E mutation positive: In combination with Braftovi® with or without FOLFOX, as subsequent therapy;
   e. If *KRAS* G12C mutation positive: In combination with Lumakras® or Krazati® following prior therapy, as subsequent therapy;

   **Prior authorization may be required.*

6. Request meets one of the following (a or b):*
   a. Dose does not exceed 6 mg/kg every 14 days;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit or documentation supports that member is currently receiving Vectibix for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 6 mg/kg every 14 days;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):

a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CRC: colorectal cancer
CapeOX: capecitabine, oxaliplatin
dMMR/MSI-H: deficient mismatch repair/microsatellite instability-high
EGFR: epidermal growth factor receptor
FDA: Food and Drug Administration
FOLFIRI: fluorouracil, leucovorin, irinotecan
FOLFOX: fluorouracil, leucovorin, oxaliplatin
KRAS: Kirsten rat sarcoma 2 viral oncogene homologue
CRC: colorectal cancer
FOLFOXIRI: fluorouracil, leucovorin, oxaliplatin, irinotecan
NRAS: neuroblastoma RAS viral oncogene homologue
POLE/POLD1: polymerase epsilon/delta

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Modified FOLFOX 6	Day 1: oxaliplatin 85 mg/m^2 IV Day 1: Folinic acid 400 mg/m^2 IV Days 1–3: 5-FU 400 mg/m^2 IV bolus on day 1, then 1,200 mg/m^2/day × 2 days (total 2,400 mg/m^2 over 46–48 hours) IV continuous infusion Repeat cycle every 2 weeks.	See dosing regimen

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
CapeOX	Day 1: Oxaliplatin 130 mg/m^2 IV Days 1–14: Capecitabine 1,000 mg/m^2 PO BID Repeat cycle every 3 weeks.	See dosing regimen
FOLFIRI	Day 1: Irinotecan 180 mg/m^2 IV Day 1: Leucovorin 400 mg/m^2 IV Day 1: Fluorouracil 400 mg/m^2 IV followed by 2,400 mg/m^2 continuous IV over 46 hours Repeat cycle every 14 days.	See dosing regimen
FOLFOXIRI	Day 1: Irinotecan 165 mg/m^2 IV, oxaliplatin 85 mg/m^2 IV, leucovorin 400 mg/m^2 IV, fluorouracil 1,600 mg/m^2 continuous IV for 2 days (total 3,200 mg/m^2) Repeat cycle every 2 weeks.	See dosing regimen
Checkpoint inhibitor therapies: Opdivo® (nivolumab) ± Yervoy® (ipilimumab) or Keytruda® (pembrolizumab)	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): dermatologic toxicity

Appendix D: KRAS/NRAS/BRAF Wild-Type Colon Cancer with Unresectable, Synchronous Liver and/or Lung Metastases or Metachronous Metastases

- The NCCN Colon Cancer Guidelines recommend that panitumumab should only be used for left-sided tumors in *KRAS/NRAS/BRAF* wild-type colon cancer with unresectable, synchronous liver and/or lung metastases or metachronous metastases. The NCCN defines the left side of the colon as splenic flexure to rectum. Evidence suggests that patients with tumors originating on the right side of the colon (hepatic flexure through cecum) are unlikely to respond to panitumumab. Data on the response to panitumumab in patients with primary tumors originating in the transverse colon (hepatic flexure to splenic flexure) are lacking.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
RAS wild-type CRC	6 mg/kg IV over 60 minutes (≤ 1,000 mg) or 90 minutes (> 1,000 mg) every 14 days	6 mg/kg

Indication	Dosing Regimen	Maximum Dose
KRAS G12C-mutated CRC	6 mg/kg IV over 60 minutes (≤ 1,000 mg) or 90 minutes (> 1,000 mg) every 14 days in combination with sotorasib	6 mg/kg

VI. Product Availability

Single-dose vials for injection: 100 mg/5 mL, 400 mg/20 mL

VII. References

1. Vectibix Prescribing Information. Thousand Oaks, CA: Amgen, Inc.; June 2025. Available at https://www.vectibix.com/. Accessed July 31, 2026.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed July 31, 2026.
3. National Comprehensive Cancer Network. Colon Cancer Version 2.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf. Accessed July 31, 2026.
4. National Comprehensive Cancer Network. Rectal Cancer Version 2.2026. Available at: http://www.nccn.org/professionals/physician_gls/pdf/rectal.pdf. Accessed July 31, 2026.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J9303	Injection, panitumumab, 10 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2022 annual review: added qualifiers that CRC is advanced, recurrent, or metastatic per NCCN; added BRAF V600E mutation positive criterion option to wild-type options as this mutation also allows for Vectibix administration per NCCN category 2A rating; simplified requirements for prior and combination therapy to align more closely with New Century Health criteria and other oncology policies for CRC; updated combination regimens per NCCN; references reviewed and updated. Template changes applied to other diagnoses/indications.	08.09.22	11.22
4Q 2023 annual review: removed reference to formulary exception policy HIM.PA.103 for Vectibix 400 mg/20 mL formulation under HIM to allow application of this policy for all Vectibix formulations under HIM; simplified criteria by removing criterion qualifier "first-line treatment" as it overlaps with subsequent-line treatment regimens and to align with NCH criteria; added CapeOx as potential combination regimen per	08.17.23	11.23

Reviews, Revisions, and Approvals	Date	P&T Approval Date
NCCN; added criterion that disease is left-sided only for colon cancer that is *KRAS/NRAS/BRAF* wild-type per NCCN & NCH, along with rationale in Appendix D; references reviewed and updated.		
4Q 2024 annual review: per NCCN – added pathways for KRAS G12C, dMMR/MSI-H, and POLE/POLD1 mutations with corresponding requirements related to combination use and/or prior therapy; removed prior therapy requirement when requested for use as a single agent; modified requirement for left-sided colon cancer to only apply to unresectable synchronous metastases; references reviewed and updated.	08.08.24	11.24
RT4: added new FDA-approved indication of *KRAS* G12C-mutated CRC; removed prior therapy requirement when prescribed for BRAF V600E mutation positive in combination with Braftovi and added clarification that regimen may be "with or without FOLFOX" per NCCN; modified requirement for left-sided colon cancer to also apply to unresectable metachronous metastases per NCCN; references reviewed and updated.	02.07.25	
4Q 2025 annual review: specified that POLE/POLD1 mutation positive disease must have ultra-hypermutated phenotype and specified that unresectable synchronous metastases are in the liver and/or lung per NCCN; extended initial approval duration for HIM/Medicaid from 6 to 12 months; revised approval durations for Commercial from 6/12 months to standard injectable authorization of "6 months or to the member's renewal date, whichever is longer"; references reviewed and updated.	07.15.25	11.25
4Q 2026 annual review: added ICHRA line of business; added off-label small bowel adenocarcinoma and appendiceal neoplasms and cancers per NCCN; for CRC per NCCN, removed specification for BRAF V600E mutation positive disease for use in combination with Braftovi, removed specification for KRAS G12C positive disease for use in combination with Lumakras or Krazati; references reviewed and updated.	07.31.26	11.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical

practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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