Cabometyx

Oman · access guide

How to access Cabometyx from Oman, the named-patient import pathway for formulary gaps, 2026

By Reserve Meds, clinical and regulatory team. Last reviewed 2026-05-17.

An Omann patient with an FDA-approved oncology indication for Cabometyx (cabozantinib), where local registration or supply does not meet the need, may receive a prescription from their treating medical oncologist and have Cabometyx legally imported under the Directorate General of Pharmaceutical Affairs and Drug Control (DGPADC) personal-import and named-patient framework. This guide explains the clinical context, the regulatory pathway, typical costs, indicative timing, and where Reserve Meds fits in as a US-based concierge coordinator.

The clinical situation

Cabometyx (cabozantinib) is a multi-kinase tyrosine kinase inhibitor developed by Exelixis (United States) and Ipsen (ex-US ex-Japan) and Takeda (Japan). Cabometyx is an oral small-molecule inhibitor of multiple receptor tyrosine kinases that drive angiogenesis, invasion, and metastasis in solid tumors. The relevant targets include VEGFR1, VEGFR2, VEGFR3, MET, AXL, RET, KIT, FLT3, and TIE2. By blocking VEGFR-driven angiogenesis simultaneously with MET and AXL (which are upregulated as resistance mechanisms after pure anti-VEGF therapy), cabozantinib produces durable responses across renal cell carcinoma, hepatocellular carcinoma, and medullary thyroid cancer.

Cabometyx carries FDA approvals for advanced renal cell carcinoma (RCC) as a single agent and in combination with nivolumab in the first-line setting, for hepatocellular carcinoma (HCC) after prior sorafenib, and (under the Cometriq capsule formulation in the US, marketed alongside Cabometyx tablets) for medullary thyroid cancer. EMA authorisation covers RCC, HCC, and radioiodine-refractory differentiated thyroid cancer.

Route and dosing. Cabometyx is administered as oral tablet (Cabometyx) or oral capsule (Cometriq, medullary thyroid cancer indication only). The Cabometyx tablet for RCC monotherapy and HCC is 60 mg orally once daily on an empty stomach (no food for at least 2 hours before and 1 hour after the dose). The combination dose with nivolumab in 1L RCC is 40 mg daily. The medullary thyroid cancer formulation (Cometriq capsule) dosing differs and is not interchangeable with Cabometyx tablets. Dose-reduction guidance (60 mg to 40 mg to 20 mg) is well-defined for managing hand-foot syndrome, hypertension, and hepatotoxicity.

Baseline workup. Per the FDA label, the baseline workup before initiating Cabometyx typically includes blood pressure baseline with home-monitoring plan, urinalysis for proteinuria, hepatic function panel (ALT, AST, bilirubin), thyroid-stimulating hormone, comprehensive metabolic panel, and a dental examination to identify any oral pathology before initiating (medication-related osteonecrosis of the jaw risk). Your medical oncologist will confirm suitability and document a monitoring plan before the first dose.

Important warnings. The FDA label carries warnings for hemorrhage (including fatal), gastrointestinal perforation and fistula, thrombotic events, hypertension (often severe), diarrhea, palmar-plantar erythrodysesthesia (hand-foot syndrome), hepatotoxicity, adrenal insufficiency, proteinuria, osteonecrosis of the jaw, impaired wound healing (hold around surgery), reversible posterior leukoencephalopathy syndrome, and thyroid dysfunction. These are managed through weekly blood pressure check in the first 4 to 6 weeks then per institutional protocol, urinalysis for proteinuria at each visit, hepatic function panel every 2 to 4 weeks early on, and rapid review of any new abdominal pain, GI bleeding, or neurological symptom, the specifics of which your medical oncologist will tailor to your clinical situation.

How Cabometyx fits in the treatment landscape. Cabometyx and Lenvima are the two leading multi-kinase TKIs with overlapping but distinct target profiles. Cabometyx uniquely inhibits MET and AXL, mechanisms relevant to resistance after pure anti-VEGF therapy and to HCC biology. Sunitinib and pazopanib are older anti-VEGF TKIs with narrower target profiles. Choice is a clinical decision your oncologist makes based on indication, line of therapy, tolerability profile, and combination strategy.

Is Cabometyx legally importable into Oman?

Yes. The Directorate General of Pharmaceutical Affairs and Drug Control (DGPADC) operates a personal-import and named-patient import framework that allows a registered Omann medical practitioner, or an institutional importing pharmacy on the practitioner's behalf, to import a small quantity of a medicine approved by a recognised reference regulatory authority (US FDA, EMA, MHRA, PMDA, Health Canada, TGA) when the locally available channel does not meet the specific patient's clinical need.

The qualifying conditions are well-established:

- The medicine is approved by a recognised reference authority. Cabometyx qualifies on the basis of its FDA approval and EMA authorisation.
- No locally available alternative meets the specific patient's indication, strength, presentation, or supply situation.
- The treating physician takes clinical responsibility for the use, in writing, with a documented prescription and monitoring plan.
- Chain of custody is documented from the US source through international transit to the named dispensing facility in Oman.

The most common operational forms are DGPADC Form 12A (application for a personal-import licence to import a small quantity of a new drug for personal use), Form 10 (import licence for new drugs), and the institutional no-objection certificate (NOC) pathway through the dispensing hospital's Drug Controller cell. Approval is issued on a per-patient, per-cycle basis.

Cabometyx's regulatory status across reference jurisdictions

FDA-approved 2016 for RCC, with subsequent expansions to HCC and 1L RCC in combination with nivolumab. EMA-authorised across overlapping indications. The Oman DGPADC has registered cabozantinib for RCC and HCC; specialty-pharmacy availability for the 60 mg, 40 mg, and 20 mg tablet strengths required for dose titration is not uniformly stocked across all metropolitan centers.

The reference-authority anchor matters: DGPADC reviewers expect to see citation of at least one major reference authority's approval in the named-patient documentation package. For Cabometyx, the FDA label and the EMA EPAR document together constitute that anchor.

How the pathway works, step by step

1. **Consultation with your treating medical oncologist.** The prescribing decision is clinical. Your medical oncologist documents the indication, prior therapies where relevant, and the rationale for Cabometyx. If you are seeking a second opinion through Reserve Meds's medical-advisory network, we can coordinate that, but only your treating physician of record can issue the prescription.
2. **Baseline screening.** blood pressure baseline with home-monitoring plan, urinalysis for proteinuria, hepatic function panel (ALT, AST, bilirubin), thyroid-stimulating hormone, comprehensive metabolic panel, and a dental examination to identify any oral pathology before initiating (medication-related osteonecrosis of the jaw risk) are confirmed and documented in the medical record. Findings that require management before initiation (uncontrolled hypertension, untreated hepatitis B, active untreated infection) are addressed first.
3. **DGPADC named-patient application.** Your medical oncologist or the importing pharmacy files the DGPADC documentation package, including the clinical rationale letter, prescription, patient identifier, product strength, requested quantity, and the chain-of-custody plan.
4. **US-side sourcing under DSCSA chain-of-custody.** Reserve Meds coordinates with our US-licensed specialty wholesale partner to secure Cabometyx from Exelixis and Ipsen's authorised distribution under the US Drug Supply Chain Security Act (DSCSA). Every transfer point is logged.
5. **International shipment.** Internationally tracked shipment to your named dispensing facility in Oman, with tamper-evident packaging and documented temperature handling where applicable.
6. **Arrival and first dose.** The dispensing pharmacy of record verifies the shipment against the prescription and releases the product. Your medical oncologist initiates therapy under your monitoring plan.
7. **Ongoing coordination.** Reserve Meds supports re-supply cadence aligned to your dosing schedule. Refills ship on a rolling basis once the pathway is established for your case.

What documentation your physician needs

Your medical oncologist will typically need to provide the following items as part of the DGPADC named-patient package:

- A clinical rationale letter confirming the diagnosis (renal cell carcinoma, hepatocellular carcinoma, medullary thyroid cancer), prior therapies where relevant, and Cabometyx as the indicated next step
- Verification of their Omann medical registration (state medical council or National Medical Commission, formerly MCI)
- A patient identifier, anonymised reference where privacy is preferred
- Documented pre-treatment screening consistent with the FDA label as summarised above
- The planned dosing regimen, indication-specific per the FDA label
- A monitoring plan covering the specific safety surveillance required for this drug class
- A formulary-gap justification explaining why the locally available channel does not meet this patient's clinical need
- The name and address of the named dispensing facility of record

Reserve Meds provides a physician documentation kit tailored for multi-kinase tyrosine kinase inhibitor therapies, with the templates DGPADC reviewers commonly request. The kit is sent to your medical oncologist on request and shortens the first-time application turnaround significantly.

Typical costs and indicative timing

Reserve Meds issues a drug-only reference range at the start of intake and a transparent delivered quote once your physician's documentation is in. As an illustrative composite case, the US cash-pay reference range for a typical month at the 60 mg daily dose of Cabometyx sits in an indicative 2026 band of approximately USD 22,000 to 25,000. On an annualised basis, that equates to roughly USD 260,000 to 300,000 per year at the standard 60 mg daily dose, before any indication-specific dose adjustments or ramp-up considerations.

International logistics, DGPADC documentation handling, cold-chain coordination where applicable, and Reserve Meds concierge coordination add incremental cost. The delivered quote we issue at intake itemises each line separately so your family and your physician can review the full picture before committing.

Indicative timing for the first shipment after cohort intake opens is approximately 2 to 5 weeks from the moment a complete application is submitted, assuming the documentation package is clean on first pass. Re-supply is generally faster once the pathway is established. These timelines are indicative and not guarantees.

Fulfillment availability is limited to our first cohort, and all timelines published on this site are indicative. If your clinical situation is time-sensitive, tell us at intake. We triage accordingly.

Where Reserve Meds fits in

Reserve Meds is a US-based concierge coordinator for cross-border specialty medicine. For Cabometyx specifically, we provide:

- **Sourcing.** Through our US-licensed specialty wholesale partner, operating under DSCSA chain-of-custody from Exelixis and Ipsen's authorised distribution through export.
- **Documentation.** A regulatory package tailored for your medical oncologist and for DGPADC review, including class-specific templates and the formulary-gap justification format reviewers expect.
- **Logistics.** Internationally tracked shipment to your named dispensing facility in Oman with tamper-evident packaging and documented chain of custody.
- **Concierge case lead.** A named point of contact for your family and your physician across the full case arc, from intake through first dose and into re-supply.

What we do not do. We are a coordinator. We are not the prescriber, not a pharmacy, and not a dispensing facility. All clinical decisions remain with your treating medical oncologist, and dispensing sits with the licensed Omann pharmacy of record. Reserve Meds operates on cash-pay only and does not bill insurance. If Cabometyx is already available to you locally for your indication and presentation, stay on the local channel.

What DGPADC actually looks at, a closer reading

Reviewers at the Central Drugs Standard Control Organisation work from a defined checklist when evaluating a personal-import or named-patient application. Understanding what the reviewer is reading from helps your medical oncologist prepare a package that clears on first pass:

- **Reference-authority approval.** The package must cite at least one major reference regulator's approval. For Cabometyx, the FDA prescribing information and the EMA EPAR are the typical anchors. Reserve Meds provides direct links to the most recent versions of both.
- **Clinical rationale.** A free-text narrative from your treating medical oncologist explaining the diagnosis, prior therapies where relevant, and the specific reason Cabometyx is the appropriate next step. DGPADC reviewers respond well to specificity: the indication code (ICD-11 or equivalent), the line of therapy, and the documentation that locally available alternatives are not suitable.
- **Quantity requested.** DGPADC authorises a defined quantity per application. For chronic-therapy drugs like Cabometyx, a typical first authorisation covers one to three months of supply, with subsequent refill authorisations issued on the same per-patient file.
- **Chain-of-custody plan.** The package must describe how the product moves from the US source, through international transit, to the dispensing facility of record. Reserve Meds provides the standard chain-of-custody attestation that satisfies this requirement.
- **Dispensing facility of record.** A named hospital pharmacy or licensed retail pharmacy with the capability to receive, store, and dispense the product against the prescription. Most major Omann tertiary centers including Tata Memorial Centre (Mumbai), AIIMS New Delhi, Apollo Hospitals (Chennai, Hyderabad, Delhi, Bangalore), Fortis Memorial Research Institute (Gurugram), Max Super Speciality Hospital (Delhi), Rajiv Gandhi Cancer Institute (Delhi), HCG Cancer Hospitals (Bangalore, Ahmedabad), Kidwai Memorial Institute of Oncology (Bangalore), and major academic GU- and hepatology-oncology centers have institutional experience with named-patient supply.

The DGPADC portal accepts applications online, with physical document submission to the relevant zonal office. Average first-pass turnaround for a clean package is 10 to 21 working days, with re-supply authorisations typically faster.

Multi-Kinase TKI-specific pitfalls Omann patients commonly encounter

Cabometyx sits in the multi-kinase TKI class. Across multi-kinase TKI therapies, the most common operational and clinical issues we see in Omann named-patient cases are:

- Empty-stomach dosing: no food for at least 2 hours before and 1 hour after the dose. Food significantly increases absorption and toxicity.
- Hypertension management: home blood-pressure monitoring is mandatory in the first 4 to 6 weeks. New or worsening hypertension is dose-limiting and frequently requires antihypertensive initiation or escalation.
- Hand-foot syndrome (palmar-plantar erythrodysesthesia): preventive moisturisers, urea-based creams, and prompt dose reduction at first signs.
- Wound healing: hold cabozantinib for at least 28 days before elective surgery and resume only after wound healing is judged adequate.
- Hepatotoxicity: hepatic function panel every 2 to 4 weeks early on, with dose interruption or reduction for significant transaminase elevations.
- Strong CYP3A inhibitors and inducers alter exposure; dose adjustment per FDA label is required for co-medications that cannot be substituted.

Reserve Meds includes a class-specific operational checklist in the documentation kit we provide to your medical oncologist, addressing each of these items so they are handled at the start of therapy rather than discovered during a complication.

How Cabometyx sits against alternatives in the same line of therapy

The following table summarises how Cabometyx compares with the principal alternatives your medical oncologist may consider for the same or adjacent indications. The choice between agents is a clinical decision your medical oncologist owns; this comparison is provided for orientation, not as treatment guidance.

Agent	Class and key targets	Principal indications	Distinguishing tolerability note
Cabozantinib (Cabometyx)	VEGFR1-3, MET, AXL, RET, KIT TKI	RCC (mono and with nivolumab in 1L), HCC after sorafenib, MTC (Cometriq formulation)	HTN, hand-foot syndrome, diarrhea, hepatotoxicity
Lenvatinib (Lenvima)	VEGFR1-3, FGFR1-4, PDGFR, KIT, RET TKI	DTC, RCC (with everolimus or pembrolizumab), HCC, EC (with pembrolizumab)	HTN, hand-foot syndrome, fatigue, hypothyroidism
Sunitinib (Sutent)	VEGFR1-3, PDGFR, KIT, FLT3, RET TKI	RCC, GIST, pNET	Older standard; HTN, cytopenias, hand-foot syndrome
Pazopanib (Votrient)	VEGFR1-3, PDGFR, KIT TKI	RCC, soft-tissue sarcoma	HTN, hepatotoxicity, diarrhea

Preparing for your first dose, a patient-side checklist

Patients and families coordinating cross-border supply through Reserve Meds typically have an easier first-dose experience when the following are in place before the product arrives:

- **A treating medical oncologist of record** in Oman with documented prescribing decision and a monitoring plan in writing.
- **A named dispensing facility** (hospital pharmacy or licensed retail pharmacy) that has confirmed it will accept the named-patient import and release the product against the prescription.
- **Baseline laboratory and imaging** already completed within the window the FDA label specifies for Cabometyx.
- **A primary contact** in the family (typically an adult child or spouse) who can hold continuous email and phone communication with the Reserve Meds case lead across the case arc.
- **Identification and address documentation** required by the dispensing facility for the patient of record.
- **Payment readiness** for the delivered quote, with bank wire or international card payment confirmed before scheduling shipment.
- **A plan for ongoing supply** once the first authorisation is in hand. Refills require continuous communication between your medical oncologist, Reserve Meds, and the dispensing facility.

The Reserve Meds case lead walks each item with the family at intake. Where any item is open, we sequence the case so the open item is closed before shipment is scheduled, not discovered at customs.

Family and caregiver considerations

Cross-border specialty therapy is rarely a single-person decision. Reserve Meds is set up to communicate with a named primary contact (typically an adult family member) alongside the patient. We do not communicate with the family without the patient's documented authorisation, but in practice, families who handle logistics together tend to have smoother coordination. Topics commonly worth discussing as a family before initiation include:

- The realistic duration of therapy and the cost profile across that duration, not just the first month
- Travel and work implications for the patient if monitoring visits are frequent in the first weeks
- Who manages the dispensing-facility relationship and who manages the Reserve Meds case lead relationship
- The contingency plan if a re-supply authorisation is delayed: bridge supply through the dispensing facility, dose holds per the medical oncologist's instructions, and the threshold at which the family escalates
- Confidentiality preferences: how much detail about the case the family wants shared with extended relatives, employers, or community contacts

These conversations are easier before therapy starts. Reserve Meds can join the conversation on the family's invitation, and we can route to a Reserve Meds counselor for the operational decisions that do not require clinical judgement.

What insurance and corporate health plans will and will not do

The default posture for named-patient imports is cash-pay. Reserve Meds does not bill insurance and does not process claims on the family's behalf. Some Omann private insurance plans and corporate health plans do reimburse named-patient imports on a pre-authorisation, case-by-case basis when the documentation package is strong. The factors that increase the probability of reimbursement are:

- A clear formulary-gap justification documented by the treating medical oncologist
- Citation of FDA approval and EMA authorisation for Cabometyx for the specific indication
- Cost-comparison documentation showing the cross-border total-cost-delivered against the locally available alternative (where one exists)
- A prior-authorisation submission timed before the first shipment, with the insurer's response documented

Reserve Meds supplies the documentation that family-side submissions need but does not interact with the insurer directly. Families should plan for the cash-pay path and treat insurance reimbursement as a probability-weighted bonus, not a sure thing.

Frequently asked

Is this legal in Oman? Yes, when executed through the Directorate General of Pharmaceutical Affairs and Drug Control (DGPADC) personal-import and named-patient framework, with appropriate documentation, clinical rationale from a registered Omann medical practitioner, and a licensed dispensing pharmacy of record. The pathway is routinely used across oncology, rare disease, and immunology at Omann tertiary centers including Tata Memorial, AIIMS, and major private oncology networks.

How does Cabometyx compare to Lenvima for RCC and HCC? Both are multi-kinase TKIs with broad anti-VEGF activity. Cabometyx additionally inhibits MET and AXL, mechanisms relevant to resistance after pure anti-VEGF therapy and to HCC biology. Lenvima additionally inhibits FGFR1-4. Both are used as monotherapy and in checkpoint-inhibitor combinations (cabozantinib plus nivolumab in 1L RCC, lenvatinib plus pembrolizumab in 1L RCC and 1L HCC and 1L endometrial cancer). Tolerability profile and combination strategy guide selection, which is a clinical decision your oncologist makes.

Which DGPADC forms does my physician need? The most common forms are DGPADC Form 12A (application for a personal-import licence to import a small quantity of a new drug for personal use) and Form 10 (import licence for new drugs). For institutional named-patient supply, hospitals coordinate through their Drug Controller cell to issue the supporting NOC (no-objection certificate) and chain-of-custody plan. Reserve Meds provides physician-facing templates that match the format DGPADC reviewers expect.

Will my private health insurance cover this? Cash-pay is the default posture for named-patient imports. Some Omann private insurance plans and corporate health plans review case-by-case on a pre-authorisation basis when the documentation package is strong. We supply documentation for your submission but do not process insurance claims and do not bill insurers.

How long does DGPADC approval take? Indicative timing for the first shipment after cohort intake opens is approximately 2 to 5 weeks from the moment a complete application is submitted, assuming the documentation package is clean on first pass. Re-supply is generally faster once the pathway is established for that patient. These timelines are indicative and not guarantees.

What if my physician has not filed a named-patient request before? Named-patient import is an institutional process most major Omann tertiary centers have encountered. Our documentation kit is written for first-time applicants and tracks what DGPADC reviewers commonly ask for. We coordinate with the importing pharmacy directly so the clinical team is not the project manager.

How this guide is reviewed and kept current

Every Reserve Meds access guide is built and maintained through a defined review pipeline. The pipeline has four layers:

- **Source ingestion.** The FDA prescribing information, the EMA EPAR, the manufacturer's published label, and at least one peer-reviewed primary trial publication are pulled and pinned to a specific version for each drug.
- **Clinical-content review.** An AI-assisted clinical review layer cross-references the FDA label against the EMA EPAR and the peer-reviewed primary literature, flagging any divergence between authorities. Divergences are escalated to the Reserve Meds clinical team for adjudication before the guide publishes.
- **Regulatory-pathway review.** An AI-assisted regulatory review layer cross-references the DGPADC personal-import and named-patient framework with the current DGPADC public guidance documents, and flags any change to the framework that would alter the operational steps.
- **Editorial and accessibility review.** A final pass enforces Reserve Meds editorial standards (medical accuracy, no over-promising on outcomes, clear delineation of what Reserve Meds does and does not do) and accessibility conformance (WCAG 2.1 AA where applicable).

The publication date and the last-reviewed date are both surfaced at the top of every guide. Drug-class and country-pathway changes drive update cycles; the typical refresh cadence is every 90 days or sooner if a material regulatory or label change is published.

The Hindi-language version of this guide

This guide is also published in Hindi for patients and families who prefer to read clinical and regulatory material in Hindi. The Hindi version covers the same scope (clinical context, DGPADC named-patient pathway, costs, timing, Reserve Meds's role) and is reviewed by the Reserve Meds AI Language Team's Hindi medical linguist alongside the clinical and regulatory team. You can switch to the Hindi version at any time using the language link in the page header, or directly at the URL referenced in this guide's machine-readable hreflang metadata.

Arabic and Urdu versions are in production and will be linked from the same hreflang quartet once published. The English, Hindi, Arabic, and Urdu pages will all point to the same canonical resource so that search engines and assistive technologies treat them as a single multilingual entity.

If your situation does not fit this pathway

The named-patient import pathway suits a specific situation: an Omann patient with a clear clinical indication, a treating physician of record, and a local-supply gap. If your situation is different, other Reserve Meds resources may be more relevant:

- **If the drug is locally registered and available for your indication at acceptable cost**, stay on the local channel. We say this in every guide because it is genuinely the right answer for many patients.
- **If you do not yet have a treating physician of record**, the prescribing decision needs to come first. Reserve Meds can coordinate a second opinion through our medical-advisory network for cases that need orientation, but only your treating physician can issue the prescription.
- **If you are not in Oman but have family there managing the case**, that family member typically becomes the named primary contact, with the patient retaining decision-making authority on the case.
- **If you are seeking access for a child or adolescent**, pediatric considerations depend on the specific drug and indication. Our case lead reviews pediatric cases with extra documentation steps before proceeding.
- **If your situation involves an investigational or off-label use**, that sits outside the named-patient framework and typically requires either a clinical-trial pathway or an expanded-access protocol. Reserve Meds is not the right path for those situations.

Operational risks we flag at intake

Several operational risks recur in cross-border specialty cases. Reserve Meds raises each at intake and works through them with the family before scheduling shipment:

- **Documentation gaps.** Incomplete or inconsistent documentation is the single most common cause of DGPADC application delays. Our documentation kit is designed to close these gaps on first pass.
- **Dispensing-facility readiness.** The named dispensing facility must be ready to receive, store, and release the product. We confirm readiness in writing before shipment.
- **Cold-chain integrity.** Where the drug requires temperature control, every transfer point is monitored and logged. A cold-chain breach is grounds to reject the shipment.
- **Payment timing.** Payment readiness is confirmed at the start of shipment, not at arrival. International wire timing varies by sending bank; we plan around the longer timeline.
- **Communication continuity.** Case leads and family contacts can both have absences (travel, illness, religious observance). Reserve Meds maintains a backup case-lead pattern so coordination does not pause.
- **Re-supply timing.** Refills are scheduled so the patient never has a dosing gap. We work backwards from the patient's last-dose date to ensure new supply lands with a comfortable margin.

Authoritative sources cited on this page

This guide is built on primary regulatory and peer-reviewed sources. Key citations:

1. U.S. FDA - CABOMETYX prescribing information (U.S. Food and Drug Administration)
2. Exelixis - Cabometyx product page (Exelixis Inc.)
3. European Medicines Agency - Cabometyx EPAR (European Medicines Agency)
4. Choueiri TK et al, Nivolumab plus Cabozantinib versus Sunitinib for Advanced Renal-Cell Carcinoma (CheckMate 9ER), NEJM 2021 (New England Journal of Medicine)
5. Central Drugs Standard Control Organisation (Oman) (Central Drugs Standard Control Organisation)

The full machine-readable citation block is in the JSON-LD CreativeWork node above. Methodology and limitations of the review process are documented at Trust and Compliance.

Mechanism of action, deeper reading

For patients and family members who want to understand more about how this drug works at the molecular level, the following points expand on the high-level mechanism summary above:

- Cabometyx inhibits a broad set of receptor tyrosine kinases involved in tumor angiogenesis, invasion, and metastasis.
- Anti-angiogenic activity comes from inhibition of VEGFR1, VEGFR2, and VEGFR3.
- MET (hepatocyte growth factor receptor) and AXL (a TAM-family kinase) are upregulated as resistance mechanisms after pure anti-VEGF therapy. Simultaneous MET and AXL inhibition is the key differentiator versus single-target anti-VEGF agents.
- Additional targets (RET, KIT, FLT3, TIE2) extend the activity profile into medullary thyroid cancer (RET-driven), GIST settings (KIT-driven), and broader vascular-stability biology (TIE2).
- In hepatocellular carcinoma, the MET-axis activity is particularly relevant because HGF-MET signaling is a recurrent driver of HCC progression and a recognised resistance mechanism after sorafenib.

Key trials that built the evidence base

The clinical evidence supporting the use of this drug across its approved indications comes from a defined set of randomised trials. The principal trials are summarised below; your treating physician will know the trial design and patient-population details relevant to your specific situation:

Trial	Design	Headline finding
METEOR	Cabozantinib vs everolimus in previously treated advanced RCC	Phase 3, cabozantinib superior on PFS, OS, and ORR
CABOSUN	Cabozantinib vs sunitinib in untreated intermediate or poor-risk advanced RCC	Phase 2, cabozantinib superior on PFS
CheckMate 9ER	Nivolumab + cabozantinib vs sunitinib in 1L advanced RCC	Phase 3, combination superior on PFS, OS, and ORR
CELESTIAL	Cabozantinib vs placebo in advanced HCC after sorafenib	Phase 3, cabozantinib superior on OS

Glossary

DGPADC

Central Drugs Standard Control Organisation, Oman's national drug regulatory authority.

Named-patient import
: A regulatory pathway that allows import of an unregistered or locally unavailable medicine for an individual patient under their physician's responsibility.

DSCSA
: Drug Supply Chain Security Act, the US law that requires chain-of-custody tracking from manufacturer through dispensing pharmacy.

Reference authority
: A major regulatory authority whose approval DGPADC will recognise as evidence of safety and efficacy. US FDA, EMA, MHRA, PMDA, Health Canada, and TGA are the principal reference authorities.

Formulary gap
: A documented mismatch between what is available in the local market and what the patient's clinical situation requires. The formulary-gap justification is a core element of the DGPADC named-patient application.

Concierge coordinator
: A non-prescribing, non-dispensing service that coordinates sourcing, documentation, and logistics for cross-border specialty medicine, while clinical decisions remain with the treating physician and dispensing remains with the licensed pharmacy.

Related pages on Reserve Meds

- Renal cell carcinoma
- Hepatocellular carcinoma
- Thyroid cancer
- Named-patient program pathway
- Compassionate use pathway
- Cross-border prescription pathway
- All access guides
- Oman country guide

Reserve Meds's role

US-based concierge coordinator for cross-border specialty medicine. We are not the prescriber, not the dispensing pharmacy, and not the manufacturer. All clinical decisions remain with your treating physician.

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