Clinical Policy: Pazopanib (Votrient)

Reference Number: CP.PHAR.81
Effective Date: 10.01.11
Last Review Date: 08.23
Line of Business: Commercial, HIM, Medicaid Revision Log

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

Description

Pazopanib (Votrient®) is a kinase inhibitor.

FDA Approved Indication(s)

Votrient is indicated for the treatment of adults with:

- Advanced renal cell carcinoma (RCC)
- Advanced soft tissue sarcoma (STS) in patients who have received prior chemotherapy

Limitation(s) of use: The efficacy of Votrient for the treatment of patients with adipocytic STS or gastrointestinal stromal tumors (GIST) has not been demonstrated.

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 Votrient is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Renal Cell Carcinoma (must meet all)**:**

1. Diagnosis of RCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is advanced, relapsed, stage IV, or von Hippel-Lindau (VHL)-associated;
5. For Votrient requests, member must use pazopanib, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 800 mg (4 tablets) per day;
   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 – 6 months
Commercial – 12 months or duration of request, whichever is less

B. Soft Tissue Sarcoma (must meet all)**:**

1. Diagnosis of STS and meets one of the following (a, b, c, or d):

a. STS subtype is angiosarcoma, desmoid tumor (aggressive fibromatosis), solitary fibrous tumor, or alveolar soft part sarcoma;
b. Member is ineligible for IV chemotherapy or is not a candidate for anthracycline-based regimens;
c. For GIST subtype, failure of one or more of the following agents, unless clinically significant adverse effects are experienced, all are contraindicated, or tumor is succinate dehydrogenase (SDH)-deficient with gross residual disease: imatinib, Qinlock™, Sutent®, Ayvakit™, Sprycel®, Stivarga®;
**Prior authorization is required for imatinib, Sutent, Ayvakit and Stivarga.*
d. For all other STS subtypes, failure of prior chemotherapy unless contraindicated or clinically significant adverse effects are experienced;

2. Prescribed by or in consultation with an oncologist;
3. Disease is stage IV, unresectable, advanced, or recurrent with metastases;
4. Age ≥ 18 years;
5. For Votrient requests, member must use pazopanib, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 800 mg (4 tablets) per day;
   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 – 6 months
Commercial – 12 months or duration of request, whichever is less

C. Uterine Sarcoma (off-label) (must meet all)**:**

1. Diagnosis of uterine sarcoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is advanced, recurrent, metastatic, or inoperable;
5. Failure of prior cytotoxic chemotherapy (hormonal therapies such as aromatase inhibitors are not considered cytotoxic);
6. For Votrient requests, member must use pazopanib, if available, unless contraindicated or clinically significant adverse effects are experienced;
7. Dose is within FDA maximum limit for any FDA-approved indication or 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 – 6 months
Commercial – 12 months or duration of request, whichever is less

D. Thyroid Carcinoma (off-label) (must meet all)**:**

1. Diagnosis of thyroid carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is unresectable, advanced or metastatic;

5. If papillary, follicular, or oncocytic (formerly known as Hurthle cell) carcinoma, disease is progressive and/or symptomatic iodine-refractory;
6. Histology meets one of the following (a or b):
   a. If papillary, follicular, or oncocytic (formerly known as Hurthle cell) carcinoma, failure of Lenvima® or Nexavar®, unless clinically significant adverse effects are experienced or both are contraindicated;*
   b. If medullary carcinoma, failure of Caprelsa® or Cabometyx®, unless clinically significant adverse effects are experienced or both are contraindicated;

   **Prior authorization is required for Lenvima, Nexavar, Caprelsa, and Cabometyx.*
7. For Votrient requests, member must use pazopanib, if available, unless contraindicated or clinically significant adverse effects are experienced;
8. Dose is within FDA maximum limit for any FDA-approved indication or 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 – 6 months
Commercial – 12 months or duration of request, whichever is less

E. Chondrosarcoma (off-label) (must meet all)**:**
1. Diagnosis of metastatic or widespread chondrosarcoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Used as single-agent therapy;
5. For Votrient requests, member must use pazopanib, if available, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose is within FDA maximum limit for any FDA-approved indication or 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 – 6 months
Commercial – 12 months or duration of request, whichever is less

F. 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) 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, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) 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, 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, 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 Votrient for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Votrient requests, member must use pazopanib, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed 800 mg (4 tablets) per day;
   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 – 12 months
Commercial – 12 months or duration of request, whichever is less

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) 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, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) 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, 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, 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 policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
GIST: gastrointestinal stromal tumor
RCC: renal cell carcinoma
STS: soft tissue sarcoma

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
Soft Tissue Sarcoma		
Chemotherapy agents (examples): doxorubicin, dacarbazine, ifosfamide, mesna, epirubicin, gemcitabine, docetaxel (Taxotere®), vinorelbine, Lartruvo® (olaratumab)	STS (not GIST): regimens vary	Varies
imatinib (Gleevec®)	GIST: 400 mg PO QD	800 mg/day
Sutent® (sunitinib)	GIST: 50 mg PO QD 4 weeks on/2 weeks off	87.5 mg/day
Stivarga® (regorafenib)	GIST: 160 mg PO QD 21 days on/7 days off	160 mg/day
Ayvakit® (avapritinib)	GIST: 300 mg PO QD, until disease progression	300 mg/day
Sprycel® (dasatinib)	GIST: 70 mg PO BID	140 mg/day
Qinlock™ (ripretinib)	GIST: 150 mg PO QD	150 mg/day
Uterine Sarcoma		
Cytotoxic chemotherapy agents (examples): doxorubicin, docetaxel, gemcitabine, Lartruvo® (olaratumab)	Regimens vary	Varies
Thyroid Cancer		
Lenvima® (lenvatinib)	Papillary, follicular, or oncocytic (formerly known as Hurthle cell) carcinoma: 24 mg PO QD	24 mg/day
Nexavar® (sorafenib)	Papillary, follicular, or oncocytic (formerly known as Hurthle cell) carcinoma: 400 mg PO BID	800 mg/day
Caprelsa® (vandetanib)	Medullary carcinoma: 300 mg PO QD	300 mg/day
Cabometyx® (cabozantinib)	Medullary carcinoma: 140 mg PO QD	180 mg/day

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): hepatotoxicity

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
RCC, STS	800 mg PO QD	800 mg/day

VI. Product Availability

Tablet: 200 mg

VII. References

1. Votrient Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; December 2021. Available at https://www.us.votrient.com. Accessed April 20, 2023.
2. Pazopanib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: http://www.nccn.org/professionals/drug_compendium. Accessed May 18, 2023.
3. National Comprehensive Cancer Network. Bone Cancer Version 3.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/bone.pdf. Accessed May 18, 2023.
4. National Comprehensive Cancer Network. Gastrointestinal Stromal Tumors (GIST) Version 1.2023. Available at https://www.nccn.org/professionals/physician_gls/pdf/gist.pdf. Accessed May 18, 2023.
5. National Comprehensive Cancer Network. Kidney Cancer Version 4.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Accessed May 18, 2023.
6. National Comprehensive Cancer Network. Soft Tissue Sarcoma Version 2.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf. Accessed May 18, 2023.
7. National Comprehensive Cancer Network. Thyroid Carcinoma Version 2.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf. Accessed May 18, 2023.
8. National Comprehensive Cancer Network. Uterine Neoplasms Version 2.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/uterine.pdf. Accessed May 18, 2023.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2019 annual review: off-label ovarian ca removed given 2B NCCN recommendation; solitary fibrous tumor/hemangiopericytoma and alveolar soft part sarcoma added per NCCN; references reviewed and updated.	05.14.19	08.19
3Q 2020 annual review: For STS subtype GIST Ayvakit added per NCCN guidelines as a possible step through drug; for STS added criteria disease is stage IV, unresectable, advanced, or recurrent with metastases as per NCCN guidelines; for uterine carcinoma added criteria disease is recurrent or metastatic; for thyroid carcinoma added criteria disease is unresectable, advanced or metastatic; if papillary, follicular, or Hurthle cell carcinoma, disease is progressive	05.04.20	08.20

Reviews, Revisions, and Approvals	Date	P&T Approval Date
and/or symptomatic iodine-refractory; off-label ovarian cancer added given 2A NCCN recommendation; references reviewed and updated.		
RT4: updated indication to specify that FDA-approved indications are for adults.	08.31.20	
3Q 2021 annual review: added NCCN-recommended off-label uses for metastatic chondrosarcoma and use as single-agent therapy; updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); references reviewed and updated.	04.02.21	08.21
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	02.28.22	05.22
3Q 2022 annual review: for RCC added additional option for von Hippel-Lindau (VHL)-associated disease per NCCN; for STS added additional option for "member is ineligible for IV chemotherapy or is not a candidate for anthracycline-based regimens" per NCCN and added Qinlock and Sprycel as additional options for prior therapies in GIST; removed ovarian cancer as an off-label use as this is a NCCN Category 2B recommendation; added generic oral oncology redirection language if available per template; references reviewed and updated.	05.02.22	08.22
Template changes applied to other diagnoses/indications.	10.12.22	
3Q 2023 annual review: per NCCN: for STS, added bypass of prior therapy or ineligibility for angiosarcoma and desmoid tumor (aggressive fibromatosis) subtypes, added bypass of prior therapy for GIST if SDH-deficient with gross residual disease; for uterine sarcoma, added additional disease qualifiers of advanced and inoperable; for thyroid carcinoma, revised "Hurthle cell" to "oncocytic" per updated terminology; references reviewed and updated.	04.20.23	08.23

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.