Clinical Policy: Pazopanib (Votrient)

Reference Number: CP.PHAR.81
Effective Date: 10.01.11
Last Review Date: 11.17
Line of Business: 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
Votrient is indicated:

- For the treatment of advanced renal cell carcinoma (RCC)
- For the treatment of advanced soft tissue sarcoma (STS) in patients who have received prior chemotherapy

Limitation 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 (which may include office chart notes and lab results) 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. Age ≥ 18 years;
3. RCC is advanced (i.e., progressive, recurrent, unresectable, or metastatic);
4. Dose does not exceed 800 mg per day (4 tablets per day).

Approval duration: 6 months

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

1. Diagnosis of STS;
2. Age ≥ 18 years;
3. Meets (a or b):
   a. FDA approved use (i, ii, and iii):
      i. STS is advanced (i.e., progressive, recurrent, unresectable, metastatic);
      ii. STS has been previously treated with chemotherapy;
      iii. Member does not have either of the following STS subtypes:
         a) Adipocytic/lipogenic STS;

b) GIST, unless member meets the off-label NCCN GIST criteria below (section I.B.2.b.i);

b. Off-label NCCN recommended use (i or ii):
   i. Votrient is prescribed for progressive GIST that is no longer responsive to one or more of the following agents:
      a) Imatinib (Gleevec);
      b) Sunitinib (Sutent);
      c) Regorafenib (Stivarga);
   ii. Votrient is prescribed as single agent palliative therapy for any of the following STS subtypes:
      a) Angiosarcoma;
      b) Retroperitoneal/intra-abdominal STS of nonliposarcomal origin AND disease is unresectable or progressive;
      c) Pleomorphic rhabdomyosarcoma;
      d) Extremity/superficial trunk or head/neck STS of nonliposarcomal origin AND disease is stage IV (synchronous metastatic disease) or recurrent with disseminated metastases;

4. Request meets any of the following (a or b):
   a. Dose does not exceed 800 mg per day (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*).

Approval duration: 6 months

C. Other diagnoses/indications

1. Refer to CP.PHAR.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy (e.g., no evidence of disease progression or unacceptable toxicity);
3. If request is for a dose increase, request meets any of the following (a or b):
   a. New dose does not exceed 800 mg per day (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*).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to CP.PHAR.57 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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.PHAR.57 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
GIST: gastrointestinal stromal tumor
NCCN: National Comprehensive Cancer Network
RCC: renal cell carcinoma
STS: soft tissue sarcoma

Appendix B: General Information

- Votrient has a black box warning for hepatotoxicity. Severe and fatal hepatotoxicity has been observed in clinical trials. It is not recommended to initiate Votrient in patients with pre-existing severe hepatic impairment (total bilirubin > 3 times the upper limit of normal).
- NCCN category 2A recommended off-label uses include: dermatofibrosarcoma protuberans, epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer when Votrient is administered in combination with weekly paclitaxel, thyroid carcinoma (follicular carcinoma, Hurthle cell carcinoma, medullary carcinoma, papillary carcinoma), and uterine sarcoma (except for stage I).

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
RCC, STS	800 mg PO QD without food Baseline moderate hepatic impairment: 200 mg PO QD. Not recommended in patients with severe hepatic impairment	800 mg/day (200 mg/day if moderate hepatic impairment)

VI. Product Availability

Tablet: 200 mg

VII. References

1. Votrient Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; May 2017. Available at https://www.us.votrient.com. Accessed July 18, 2017.
2. Pazopanib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at NCCN.org. Accessed July 18, 2017.
3. Kidney cancer (Version 2.2017). In: National Comprehensive Cancer Network Guidelines. Available at NCCN.org. Accessed July 18, 2017.
4. Soft tissue sarcoma (Version 2.2017). In: National Comprehensive Cancer Network Guidelines. Available at NCCN.org. Accessed July 18, 2017.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added clinical trial data on efficacy to background Added dosing & dose modification information Added monotherapy & special population sections Removed Appendix on Malignant adipocyte soft tissue sarcoma subtypes Added Appendix B: Conditions that preclude initiation of Votrient Revised Appendix C: Discontinuation due to safety concerns Moved safety concerns to Appendix D Added Appendix E: Drug interactions Votrient algorithm changes: Added "Currently receiving other chemotherapy?", combined total bilirubin criteria for initiation and continuation into Appendix B and C, added baseline LFT requirement for initiation	12.14	01.15
Converted policy to new template. Criteria: added age restriction; added explanatory detail per NCCN guidelines around the term 'advanced' in the context of RCC and STS; added max dose and monotherapy criteria; changed initial approval period to 3 months; removed baseline LFT question (hepatotoxicity included in safety appendix). Safety appendices B, C, D and E combined into criteria points	12.15	01.16
Converted policy to new template. Removed prescriber and age requirements per template guidelines. In initial criteria, removed exclusions based on medical conditions if they were presented in the PI as discontinuation recommendations (they are maintained under continuation criteria). Added NCCN recommended uses.	11.16	01.17
Converted policy to new template. Added age limit as safety and efficacy have not been established in pediatric populations. Removed the following safety criteria: hepatotoxicity (although it is a BBW, the action to mitigate risk is limited to withholding the drug); hemoptysis, cerebral hemorrhage, clinically significant gastrointestinal hemorrhage, or an arterial thromboembolic event in the past 6 months (they are not absolute contraindications or BBW); and all reasons to discontinue per new safety strategy. Added requirement for positive response to therapy. Added max dose criteria for STS and continued therapy. Increased approval durations from 3/6 months to 6/12 months.	07.18.17	11.17

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.

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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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