Clinical Policy: Tivozanib (Fotivda)

Reference Number: CP.PHAR.538
Effective Date: 06.01.21
Last Review Date: 05.23
Line of Business: Commercial, HIM, Medicaid

Revision Log

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

Description

Tivozanib (Fotivda®) is a tyrosine kinase inhibitor.

FDA Approved Indication(s)

Fotivda is indicated for the treatment of adult patients with relapsed or refractory advanced renal cell carcinoma (RCC) following two or more prior systemic therapies.

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

I. Initial Approval Criteria

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

1. Diagnosis of advanced RCC with clear cell histology;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is relapsed or refractory following at least 2 prior systemic therapies (*see Appendix B*);
5. For brand Fotivda requests, member must use generic tivozanib, 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 1.34 mg per day for 21 days, followed by 7 days off treatment, for every 28-day cycle;
   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. 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. Renal Cell Carcinoma (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Fotivda for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For brand Fotivda requests, member must use generic tivozanib, 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 1.34 mg per day for 21 days, followed by 7 days off treatment, for every 28-day cycle;
   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
RCC: renal cell carcinoma

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
Regimens for clear cell histology: • Inlyta® (axitinib) + Keytruda® (pembrolizumab) • Cabometyx® (cabozanitinib) + Opdivo® (nivolumab) • Lenvima® (lenvatinib) + Keytruda (pembrolizumab) • Votrient® (pazopanib) • Sutent® (sunitinib) • Yervoy® (ipilumab) + Opdivo (nivolumab) • Cabometyx (cabozanitinib) • Inlyta (axitinib) + Bavencio® (avelumab) • Proleukin® (aldesleukin) • Torisel® (temsirolimus) • Opdivo (nivolumab) • Lenvima (lenvatinib) + Afinitor® (everolimus) • Avastin® (bevacizumab) • Nexavar® (sorafenib) • Inlyta (axitinib)	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

None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
RCC	1.34 mg PO QD for 21 days on treatment followed by 7 days off treatment (28-day cycle) until disease progression or unacceptable toxicity Reduce the dose to 0.89 mg/day for patients with moderate hepatic impairment	1.34 mg/day

VI. Product Availability

Capsules: 1.34 mg, 0.89 mg

VII. References

1. Fotivda Prescribing Information. Boston, MA: AVEO Pharmaceuticals, Inc.; March 2021. Available at: https://www.aveooncology.com/fotivdapi.pdf. Accessed January 11, 2023.
2. National Comprehensive Cancer Network. Kidney Cancer Version 3.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Accessed January 11, 2023.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	03.16.21	05.21
2Q 2022 annual review: modified commercial approval duration from length of benefit to "12 months or duration of request, whichever is less"; references reviewed and updated.	02.10.22	05.22
Template changes applied to other diagnoses/indications.	10.05.22	
2Q 2023 annual review: clarified requirement that RCC is of clear cell histology per NCCN and pivotal clinical trial inclusion criteria, updated *Appendix B* to remove references to regimens for non-clear cell histology; references reviewed and updated.	01.11.23	05.23

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.