Clinical Policy: Axitinib (Inlyta)

Reference Number: CP.PHAR.100
Effective Date: 05.01.12
Last Review Date: 02.18
Line of Business: Commercial, Medicaid

Revision Log

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

Description

Axitinib (Inlyta®) is a kinase inhibitor.

FDA Approved Indication(s)

Inlyta is indicated for treatment of advanced renal cell carcinoma (RCC) after failure of one prior systemic therapy.

Policy/Criteria

Provider must submit documentation (including 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 Inlyta 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. One of the following (a or b):
   a. For RCC with predominant clear cell histology: Member has received one prior therapy (e.g., Votrient; Sutent);
   b. RCC with non-clear cell histology (off-label);
5. Dose does not exceed 10 mg orally twice daily.

Approval duration:
Medicaid - 6 months
Commercial – Length of benefit or until disease progression

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

1. Diagnosis of follicular, Hurthle cell or papillary thyroid carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is iodine-refractory and either unresectable or metastatic;
5. Request meets one of the following (a or b):
   a. Dose does not exceed 10 mg orally twice daily;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

Approval duration:
Medicaid - 6 months
Commercial – Length of benefit or until disease progression

C. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Inlyta for RCC or thyroid carcinoma and has received this medication for at least 30 days;
2. Member is responding positively to therapy (e.g., no disease progression or unacceptable toxicity);
3. If request is for a dose increase, request meets one of the following (a or b):
   a. New dose does not exceed 10 mg twice daily;
   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:
Medicaid - 12 months
Commercial – Length of benefit or until disease progression

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 the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial 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 and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Sutent® (sunitinib)	Advanced RCC: 50 mg PO QD for 4 weeks followed by 2 weeks off.	Advanced RCC: 87.5 mg/day
Votrient® (pazopanib)	Advanced RCC: 800 mg PO QD	Advanced RCC: 800 mg/day Treatment continues until no longer clinically beneficial or until unacceptable toxicity occurs.
Avastin® (bevacizumab) in combination with Intron A (interferon alfa-2b)	Advanced RCC: 10 mg/kg IV infused over 60-90 minutes every 2 weeks in combination with interferon alfa 3 million IU SC/IM 5 times per week up to 36 million IU SC/IM 3 times per week	Advanced RCC: 15 mg/kg every 3 weeks or 10 mg/kg every 2 weeks in combination with interferon alfa 20 million IU/m^2/day IV; 35 million IU/m^2/dose SC/IM
Torisel® (temsirolimus)	Advanced RCC: 25 mg IV once weekly until disease progression or unacceptable toxicity	Advanced RCC: 25 mg IV once weekly
Proleukin® (aldesleukin)	Advanced RCC: 600,000 units/kg every 8 hours for a maximum of 14 doses; repeat after 9 days for a total of 28 doses per course	Advanced RCC: 600,000 units/kg every 8 hours

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: General Information

- For RCC, NCCN makes the following recommendations for axitinib as single-agent therapy for relapse or surgically unresectable stage IV disease:
  - Category 2A for first-line therapy for predominant clear cell histology
  - Category 1 for subsequent therapy for predominant clear cell histology
  - Category 2A for first line therapy for non-clear cell histology
- For thyroid carcinoma, NCCN makes the following recommendation for axitinib for unresectable recurrent, persistent locoregional, or distant metastatic disease:
  - Category 2A if clinical trials or other systemic therapies are not available or appropriate

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Renal cell carcinoma	Starting dose: 5 mg PO BID	10 mg PO BID

VI. Product Availability

Tablets: 1 mg, 5 mg

VII. References

1. Inlyta Prescribing Information. New York, NY: Pfizer Labs, Inc.; August 2014. Available at http://labeling.pfizer.com/ShowLabeling.aspx?id=759. Accessed November 2017.
2. Axitinib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at nccn.org. Accessed November 2017.
3. Kidney cancer (Version 1.2018). In: National Comprehensive Cancer Network Guidelines. Available at NCCN.org. Accessed November 2017.
4. Thyroid carcinomas (Version 2.2017). In: National Comprehensive Cancer Network Guidelines. Available at NCCN.org. Accessed November 2017.
5. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2017. Available at: http://www.clinicalpharmacology-ip.com/.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Updated background and safety sections. Removed duplicate questioning within algorithm regarding prior use of Inlyta.	06.14	06.14
Updated RCC statistics in background section. Added contraindications and monitoring requirements in algorithm as outlined in new appendices. Updated references	04.15	05.15
Policy converted to new template. Requests for documentation are removed for renal cell carcinoma. Defined advanced renal cell cancer per NCCN compendium. Allow first-line use (based on NCCN recommendation) when other FDA approved systemic therapies for renal cell cancer are contraindicated or unavailable. Removed requirement for baseline monitoring and oncologist prescriber. Added approval criteria for thyroid carcinoma per NCCN 2A recommendation.	04.16	05.16
Renal cancer is reorganized around FDA labeled and NCCN recommended uses; dosing removed. Approval duration changed to 6 months for initial and 12 months for continued for indications specifically addressed in the policy. Safety criteria is removed as there are no contraindications or black box warnings.	03.17	04.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q18 annual review: - Policies combined for Medicaid and Commercial lines of business. - Age, specialist and dosing added. - Renal cell carcinoma: definition of "advanced" removed given the additional requirement of a prior systemic therapy. - References reviewed updated.	11.22.17	02.18

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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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.