Clinical Policy: Axitinib (Inlyta)

Reference Number: CP.PHAR.100
Effective Date: 05.01.12
Last Review Date: 05.22
Line of Business: Commercial, HIM, 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:

- In combination with avelumab, for the first-line treatment of patients with advanced renal cell carcinoma (RCC).
- In combination with pembrolizumab, for the first-line treatment of patients with advanced RCC.
- As a single agent, for the treatment of advanced 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 relapsed, metastatic, or stage IV RCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For Inlyta requests, member must use axitinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Prescribed in one of the following ways (a or b):
   a. As single-agent therapy;
   b. For clear cell histology, in combination with Keytruda® or Bavencio®;*
   **Prior authorization may be required*
6. Request meets one of the following (a or b):*
   a. Dose does not exceed 20 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. Thyroid Carcinoma (off-label) (must meet all):
1. Diagnosis of differentiated thyroid carcinoma (DTC; i.e., follicular, Hurthle cell or papillary thyroid carcinoma);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For Inlyta requests, member must use axitinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Disease is unresectable locoregional recurrent, persistent, or metastatic;
6. Failure of Lenvima® or Nexavar®, unless both are contraindicated or clinically adverse effects are experienced;
   **Prior authorization may be required*
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

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, 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 Inlyta for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Inlyta requests, member must use axitinib, 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 20 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. 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, 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

DTC: differentiated thyroid carcinoma
FDA: Food and Drug Association
NCCN: National Comprehensive Cancer Network
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
DTC		
Lenvima (lenvatinib)	24 mg PO QD	24 mg/day
Nexavar (sorafenib)	400 mg PO QD	400 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

None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
RCC	Single-agent therapy • 5 mg PO BID Combination therapy: • 5 mg PO BID with avelumab 800 mg every 2 weeks. • 5 mg PO BID with pembrolizumab 200 mg every 3 weeks or 400 mg every 6 weeks.	20 mg/day

VI. Product Availability

Tablets: 1 mg, 5 mg

VII. References

1. Inlyta Prescribing Information. New York, NY: Pfizer Labs, Inc.; June 2020. Available at http://labeling.pfizer.com/ShowLabeling.aspx?id=759. Accessed November 9, 2021.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: nccn.org. Accessed November 9, 2021.
3. National Comprehensive Cancer Network Guidelines. Kidney Cancer Version 3.2022. Available at: nccn.org. Accessed November 9, 2021.
4. National Comprehensive Cancer Network Guidelines. Thyroid Carcinoma Version 3.2021. Available at: nccn.org. Accessed November 9, 2021.
5. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc. Updated periodically. Accessed November 9, 2021.

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
1Q 2019 annual review; HIM line of business added; commercial approval duration changed from LOB or disease progression to LOB; thyroid carcinoma - DTC is added to diagnosis for clarity, metastatic/iodine refractory is removed and a drug trial is added per NCCN; references reviewed and updated.	11.13.18	02.19
1Q 2020 annual review: for RCC with clear cell histology added additional approval pathway for concurrent use with Keytruda or Bavencio consistent with NCCN Compendium; references reviewed and updated.	10.24.19	02.20
1Q 2021 annual review: oral oncology generic redirection language added; for RCC, relapsed, stage IV, or metastatic disease added, clear cell histology restriction limited to combination therapy with Keytruda and Bavencio, single-agent first-line therapy added per NCCN; for thyroid carcinoma, persistent disease added per NCCN; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	11.14.20	02.21
1Q 2022 annual review: no significant changes; clarified oral oncology generic redirection language to "must use"; references reviewed and updated.	11.09.21	02.22
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	01.20.22	05.22

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.