I. Medication Description

Pazopanib (Votrient) is an oral multikinase angiogenesis inhibitor. It targets the vascular endothelial growth factor receptor (VEGFR)-1, VEGFR-2, and VEGFR-3; platelet-derived growth factor (PDGF) receptor; fibroblast growth factor receptor (FGFR)-1 and FGFR-3; cytokine receptor (Kit); interleukin-2 receptor inducible T-cell kinase; leukocyte-specific protein tyrosine kinase; and transmembrane glycoprotein receptor tyrosine kinase.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

III. Policy

Coverage for Votrient is provided for treatment of the following conditions when prescribed by an oncologist:

- Renal Cell Carcinoma
  - First line therapy as a single agent for relapsed or stage IV disease OR
  - Subsequent therapy as a single agent for relapsed or stage IV disease with predominant clear cell histology

- Soft Tissue Sarcoma
  - Carcinoma of the extremities/trunk, head/neck: single agent palliative therapy for cancers of nonliposarcomal origin for synchronous stage IV or recurrent disease with disseminated metastases
  - Gastrointestinal Stromal Tumors (GIST): treatment for progressive disease when the patient is no longer receiving benefit from imatinib, sunitinib, or regorafenib
  - Retroperitoneal/intra-abdominal: single agent palliative therapy for cancers of nonliposarcomal origin for unresectable or progressive disease
  - Pleomorphic Rhabdomyosarcoma: single agent palliative therapy
  - Angiosarcoma: single agent palliative therapy

- Thyroid Carcinoma
  - Follicular, Hurthle cell, or Papillary carcinomas: Consider if clinical trials or other systemic therapies are not available or appropriate for treatment of progressive and/or symptomatic iodine-refractory
    - Unresectable recurrent or persistent locoregional disease
    - Distant metastatic disease
Medullary carcinoma: Consider for treatment of progressive disease or symptomatic distant metastases if
  ▪ Clinical trials, vandetanib, or cabozanitib are not available or inappropriate
  ▪ There is progression on vandetanib or cabozanitib

• Uterine Sarcoma as a single agent for non-stage I disease:
  o For disease not suitable for primary surgery
  o Following total hysterectomy with or without bilateral salpingo-oophorectomy (TH +/- BSO)
  o Following TH +/- BSO for stage IV disease
  o For a radiologically isolated vaginal/pelvic recurrence
  o For extrapelvic recurrence with no prior radiation therapy
  o For isolated metastases. Consider postoperative therapy for resectable isolated metastases
  o For disseminated metastases

• Non-Melanoma Skin Cancers – dermatofibrosarcoma protuberans: For metastatic disease

• Ovarian Cancer- epithelial ovarian cancer/ fallopian tube cancer/primary peritoneal cancer:
  o In combination with weekly paclitaxel as preferred therapy, if platinum resistant for persistent disease or recurrence

IV. Quantity Limitations

120 tablets per month
  • 800mg per day
  • 24,000mg per month

V. Coverage Duration

Initial coverage is provided for 3 months and may be renewed in up to 6 month intervals.

VI. Coverage Renewal Criteria

Coverage can be renewed in up to 6 month intervals based upon the following criteria:
  • Tumor response with stabilization of disease or decrease in size of tumor or tumor spread AND
  • Absence of unacceptable toxicity from the drug

VII. Billing/Coding Information

Available as 200mg tablets

VIII. Summary of Policy Changes

• 6/15/12: addition of criteria/information for coverage in thyroid carcinoma
• 3/15/13: addition of criteria/information for coverage in soft tissue sarcoma
• 3/15/14: addition of criteria for coverage in rhabdomyosarcoma and angiosarcoma; addition of criteria for coverage in uterine sarcoma
3/15/15: added indication for non-melanoma skin cancers
4/30/15: updated criteria for coverage in RCC based on NCCN guideline update
7/1/15: formulary distinctions made
3/15/16: updated criteria to correspond with current NCCN treatment guidelines
1/1/17: policy updated to correspond with current NCCN treatment guidelines

IX. References

1. UpToDate Online, retrieved September 2010
3. Facts and Comparisons Online, retrieved September 2010

The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

Drug therapy initiated with samples will not be considered as meeting medical necessity for coverage for non-preferred or prior authorized medications.

The preceding policy applies only to members for whom the above named pharmacy benefit medications are included on their covered formulary. Members with closed formulary benefits are subject to trying all appropriate formulary alternatives before a coverage exception for a non-formulary agent will be considered.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.