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 of Votrient is available when the following criteria have been met:
- Member is at least 18 years of age AND
- The medication is prescribed by a hematologist/oncologist AND
- The requested use is supported by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines (NCCN Guidelines®) and/or NCCN Drugs & Biologics Compendium (NCCN Compendium®) with a recommendation of category level 1 or 2A.

IV. Quantity Limitations

Coverage is available for up to 120 tablets per month.

V. Coverage Duration

Initial coverage is provided for 6 months and may be renewed.

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
- 1/1/18: coverage criteria updated to allow use as supported by current NCCN guidelines

IX. References

1. Up-to-date 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.

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 medication 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.