Clinical Policy Title:	lenvatinib
Policy Number:	RxA.198
Drug(s) Applied:	Lenvima®
Original Policy Date:	02/07/2020
Last Review Date:	01/01/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Differentiated Thyroid Cancer (must meet all)**:**

1. Diagnosis of recurrent or metastatic DTC (i.e., papillary, follicular,or Hürthle cell carcinoma);
2. Prescribed by or in consultation with an oncologist;
3. Disease is radioactive iodine-refractory;

Approval Duration

All Lines of Business (except Medicare): 12 months

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

1. Diagnosis of advanced RCC
2. Prescribed by or in consultation with an oncologist;
3. Prescribed in one of the following (a or b);
   a. First line treatment in combination with Keytruda®;
   b. Treatment follows one prior anti-angiogenic therapy (e.g Inlyta®, Sutent®, Votrient®, or Cabometyx®) in combination with Afinitor®;

Approval Duration

All Lines of Business (except Medicare): 12 months

C. Hepatocellular Carcinoma (must meet all)**:**

1. Diagnosis of hepatocellular carcinoma;
2. Prescribed by or in consultation with an oncologist;

Approval Duration

All Lines of Business (except Medicare): 12 months

D. Endometrial Carcinoma (must meet all)**:**

1. Diagnosis of advanced endometrial carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Prescribed in combination with Keytruda®;
4. Disease is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR);
5. Disease has progressed following prior systemic therapy (e.g., carboplatin/paclitaxel);
6. Member is not a candidate for curative surgery or radiation;

Approval Duration

All Lines of Business (except Medicare): 12 months

E. Medullary Thyroid Carcinoma (off-label) (must meet all)**:**
1. Diagnosis of medullary thyroid carcinoma (MTC);
2. Prescribed by or in consultation with an oncologist;
3. Trial and failure of Cometriq® or Caprelsa®, Gavreto®, Retevmo®, unless contraindicated or clinically significant adverse effects are experienced or there is progression despite treatment*

Approval Duration
All Lines of Business (except Medicare): 12 months

F. Thymomas and Thymic Carcinomas (off-label):
1. Diagnosis of thymic carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Prescribed as single agent therapy for members who have not tolerated or responded carboplatin/paclitaxel;

Approval Duration
All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. All Indications in Section I (must meet all)**:**
1. Member is currently receiving or has been treated with this medication within the past 90 days, excluding manufacturer samples.

Approval Duration
All Lines of Business (except Medicare): 12 months

References

1. National Comprehensive Cancer Network. Thyroid Carcinoma Version 3.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf. Accessed January 05, 2024.
2. National Comprehensive Cancer Network. Kidney Cancer Version 3.2023. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Accessed January 05, 2024.
3. National Comprehensive Cancer Network. Hepatobiliary Cancers Version 3.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hepatobiliary.pdf. Accessed January 05, 2024.
4. National Comprehensive Cancer Network. Uterine Neoplasms Version 1.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/uterine.pdf. Accessed January 05, 2024.
5. Chemotherapy Drug Information Available at: http://chemocare.com/chemotherapy/drug-info/lenvatinib.aspx. Accessed January 05, 2024.
6. National Comprehensive Cancer Network. Thymomas and Thymic Carcinomas Version 2.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/thymic.pdf. Accessed January 05, 2024.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
Policy was reviewed: 1) Policy title was updated. 2) Continued Therapy Approval criteria II.A.1 was rephrased. 3) Appendices were updated. 4) References were updated.	06/15/2020	09/14/2020

Policy was reviewed: 1) Clinical policy Initial Approval Criteria (2) off label indications added for Thymomas and Thymic Carcinomas & Thyroid Carcinoma - Anaplastic Carcinoma. 2) References were revised and added. 3) Updated initial criteria in section I.B to include criteria for anaplastic carcinoma (NCCN 2A recommendation) 4) Updated section I.C initial approval criteria for RCC for non-clear cell histology 5) Updated section I.D.4 initial approval criteria for HCC to elaborate on who is eligible for therapy. Added I.D.5 6) Added initial approval criteria for NCCN 2A recommendation – thymomas and thymic carcinomas in section I.F	03/03/2021	06/10/2021
Policy was reviewed: 1. Initial Approval Criteria I.D.4 was updated to," Member must meet the following (a, b, c or d) "from" Member must meet the following".	12/21/2021	01/17/2022
Policy was reviewed: 1. Initial Approval Criteria, I.B: Updated to remove approval criteria for Anaplastic Thyroid Carcinoma. 2. Initial Approval Criteria, Updated: a. I.C.4: Updated to remove will be used in combination with Afinitor®; b. I.C.5: Updated to remove If RCC histology is clear cell, failure of a prior first-line RCC therapy (see Appendix B) unless contraindicated or clinically adverse effects are experienced; c. I.C.6: Updated to remove If RCC histology is non-clear cell, used as systemic therapy d. I.C.7.a: Updated dosing criteria from Dose does not exceed 18 mg per day; to Dose does not exceed 18 mg per day in combination with everolimus; e. I.C.7.b: Updated to include new dosing criteria Dose does not exceed 20 mg per day in combination with pembrolizumab. 3. I.C.4: Updated to add Member meets one of the following (a or b); a. Will be used in combination with Keytruda®;	01/18/2022	04/18/2022

b. Will be used in combination with Afinitor® and member meets one of the following (i or ii); i. If RCC histology is clear cell, failure of a prior antiangiogenic therapy (e.g Inlyta, Sutent, Votrient, or Cabometyx) unless contraindicated or clinically adverse effects are experienced; ii. If RCC histology is non- clear cell, used as systemic therapy; 4. Initial Approval Criteria I.B.4.b updated to add Gavetro and Retevmo. 5. Initial Approval Criteria I.D.4.a updated to remove liver function is classified as Child Pugh class A. 6. Continued therapy approval criteria, II.A.3.b: Updated dosing criteria from New dose does not exceed 18 mg per day; to New dose does not exceed 18 mg per day in combination with everolimus or 20 mg per day in combination with pembrolizumab; 7. References were reviewed and updated.		
Policy was reviewed: 1. Initial Approval Criteria, I.A, I.B, I.C, I.D, I.E and I.F: Updated Approval Duration from 6 months to 12 months for Commercial. 2. Initial Approval Criteria, I.C.4: Updated combination therapy criteria from Member meets one of the following (a or b); a. Will be used in combination with Keytruda®; b. Will be used in combination with Afinitor® and member meets one of the following (i or ii); i. If RCC histology is clear cell or unknown, failure of a prior antiangiogenic therapy (e.g Inlyta®, Sutent®, Votrient®, or Cabometyx®) unless contraindicated or clinically adverse effects are experienced;. ii. If RCC histology is non- clear cell, used as systemic therapy; to Prescribed in one of the following (a or b); a. In combination with Keytruda®; b. In combination with Afinitor® and:	01/18/2023	04/13/2023

i. If RCC histology is clear cell or unknown, failure of a prior antiangiogenic therapy (e.g Inlyta®, Sutent®, Votrient®, or Cabometyx®) unless contraindicated or clinically adverse effects are experienced. 3. Initial Approval Criteria, I.D.1: Updated indication from Diagnosis of unresectable hepatocellular carcinoma to Diagnosis of hepatocellular carcinoma. 4. Initial Approval Criteria, I.D.4.: Updated to remove prior disease progression criteria "Member must meet one of the following (a, b, or c): a. Have unresectable disease and are not a transplant candidate; b. Have liver-confined disease, inoperable by performance status, comorbidity or with minimal or uncertain extrahepatic disease; c. Have metastatic disease or extensive liver tumor burde." 5. Initial Approval Criteria, I.D.5: Updated to remove prior criteria pertaining to indication Hepatocellular Carcinoma, "Prescribed as single agent therapy". 6. Initial Approval Criteria, I.E.5: Updated diagnostic criteria from Disease is not MSI-H or dMMR (i.e., disease is not indicative of MMR gene mutation or loss of expression) to Disease is not MSI-H or pMMR. 7. Initial Approval Criteria, I.F.2: Updated to remove prior prescribing criteria " Used as single agent for one of the following (a, b, or c): a. Prescribed as first line therapy for members who cannot tolerate combination regimens for any of the following: i. Unresectable locally advanced disease in combination with radiation therapy; ii. Potentially resectable locally advanced disease; iii. Potentially resectable solitary metastasis or ipsilateral pleural metastasis; iv. Consideration following surgery for		

solitary metastasis or ipsilateral pleural metastasis; v. Extrathoracic metastatic disease. b. Prescribed for postoperative treatment for members who are unable to tolerate first-line combination regimens after R1 or R2 resection; c. Prescribed as second-line therapy for one of the following: i. Unresectable disease following first-line chemotherapy for potentially resectable locally advanced disease, solitary metastasis, or ipsilateral pleural metastasis; ii. Extrathoracic metastatic disease. 8. Initial Approval Criteria, I.F.4: Updated to include new criteria pertaining to indication Thymic Carcinomas, Prescribed as single agent therapy for members who have not tolerated or responded to NCCN recommended agents (see Appendix B); 9. References were reviewed and updated.		
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed. 1. Removed age criteria. 2. Removed dosing criteria. 3. Removed reauthorization requirement for positive response to therapy.	12/5/2023	11/30/2023
Policy was reviewed. 1. Updated diagnosis criteria for RCC. 2. Removed disease status for MTC 3. References were reviewed and updated.	01/05/2024	01/01/2024