Clinical Policy: Lenvatinib (Lenvima)
Reference Number: CP.PHAR.138
Effective Date: 12.01.18
Last Review Date: 11.20
Line of Business: Commercial, HIM, Medicaid

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

Description
Lenvatinib (Lenvima®) is a kinase inhibitor.

FDA Approved Indication(s)
Lenvima is indicated:
- For the treatment of patients with locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer (DTC).
- In combination with everolimus for the treatment of patients with advanced renal cell carcinoma (RCC) following one prior anti-angiogenic therapy.
- For the first-line treatment of patients with unresectable hepatocellular carcinoma (HCC).
- In combination with pembrolizumab, for the treatment of patients with advanced endometrial carcinoma (EC) that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR), who have disease progression following prior systemic therapy and are not candidates for curative surgery or radiation. This indication is approved under accelerated approval based on tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trial.

Policy/Criteria
Provider must submit documentation (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 Lenvima is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Differentiated Thyroid Cancer (must meet all):
      1. Diagnosis of DTC (i.e., papillary, follicular, or Hürthle cell carcinoma);
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. Disease is radioactive iodine-refractory and recurrent, metastatic, or progressive;
      5. Request meets one of the following (a or b):*
         a. Dose does not exceed 24 mg (3 capsules) 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:
B. Medullary or Anaplastic Thyroid Carcinoma (off-label) (must meet all):
   1. Diagnosis of one of the following thyroid carcinomas (a or b):
      a. Medullary thyroid carcinoma (MTC), and both i and ii:
         i. Disease is recurrent, progressive, or metastatic;
         ii. Failure of Cometriq® or Caprelsa®, unless clinically significant adverse effects
             are experienced or both are contraindicated;
             *Prior authorization may be required for Cometriq and Caprelsa.
      b. Anaplastic thyroid carcinoma (ATC), and both i and ii:
         i. Disease is metastatic;
         ii. Prescribed as single agent therapy for members who have not tolerated or
             responded to NCCN recommended agents (see Appendix B);
   2. Prescribed by or in consultation with an oncologist;
   3. Age ≥ 18 years;
   4. Request meets one of the following (a or b):*
      a. Dose does not exceed 24 mg (3 capsules) per day.
      b. 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 – Length of Benefit

C. Renal Cell Carcinoma (must meet all):
   1. Diagnosis of advanced RCC (i.e., relapsed, metastatic, or stage IV disease);
   2. Prescribed by or in consultation with an oncologist;
   3. Age ≥ 18 years;
   4. Prescribed in combination with Afinitor®;
   *Prior authorization may be required for Afinitor
   5. If RCC histology is clear cell or unknown, failure of a prior RCC therapy (see
      Appendix B), unless clinically adverse effects are experienced or all are
      contraindicated;
   *Prior authorization may be required for prior RCC therapies
   6. Request meets one of the following (a or b):*
      a. Dose does not exceed 18 mg 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 – Length of Benefit

D. Hepatocellular Carcinoma (must meet all):
   1. Diagnosis of HCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):
   a. Dose does not exceed 12 mg per day (if actual body weight ≥ 60 kg) or 8 mg per day (if actual body weight < 60 kg);
   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 – Length of Benefit

**E. Endometrial Carcinoma (must meet all):**
1. Diagnosis of EC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed in combination with Keytruda®;
   *Prior authorization may be required for Keytruda
5. Disease is not MSI-H or dMMR (i.e., disease is not indicative of MMR gene mutation or loss of expression);
6. Disease has progressed following prior systemic therapy (e.g., carboplatin/paclitaxel);
7. Member is not a candidate for curative surgery or radiation;
8. Request meets one of the following (a or b):
   a. Dose does not exceed 20 mg (2 capsules) 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 – Length of Benefit

**F. 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.PHAR.21 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 Lenvima for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a, b, c, d, or e):
   a. DTC, MTC, ATC: New dose does not exceed 24 mg (3 capsules) per day;
   b. RCC: New dose does not exceed 18 mg per day;
c. HCC: New dose does not exceed 12 mg per day (if actual body weight ≥ 60 kg) or 8 mg (if actual body weight < 60 kg);
d. EC: New dose does not exceed 20 mg (2 capsules) per day;
e. 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/HIM – 12 months
Commercial – Length of Benefit

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.PHAR.21 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.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
ATC: anaplastic thyroid cancer
DTC: differentiated thyroid cancer
dMMR: mismatch repair deficient
EC: endometrial carcinoma
FDA: Food and Drug Administration
HCC: hepatocellular carcinoma
MSI-H: microsatellite instability-high
MTC: medullary thyroid cancer
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 for all relevant lines of business and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afinitor (everolimus)</td>
<td>RCC: 10 mg PO QD</td>
<td>10 mg/day</td>
</tr>
<tr>
<td>RCC therapeutic agents:</td>
<td>RCC: varies</td>
<td>Varies</td>
</tr>
<tr>
<td>Avastin® (bevacizumab)</td>
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<tr>
<td>Cabometyx® (cabozantinib)</td>
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<td></td>
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<tr>
<td>Inlyta® (axitinib)</td>
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<td></td>
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<tr>
<td>Nexavar® (sorafenib)</td>
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</tr>
</tbody>
</table>
## Drug Name

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opdivo® (nivolumab)</td>
<td>MTC: 300 mg PO QD</td>
<td>300 mg/day</td>
</tr>
<tr>
<td>Proleukin® (aldesleukin, rIL-2)</td>
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<td></td>
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<tr>
<td>Sutent® (sunitinib)</td>
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<td>Tarceva® (erlotinib)</td>
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<td>Torisel® (temsirolimus)</td>
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<td></td>
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<td>Votrient® (pazopanib)</td>
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<td>Yervoy® (ipilimumab)</td>
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<tr>
<td>Caprelsa® (vandetanib)</td>
<td>MTC: 140 to 180 mg PO QD</td>
<td>180 mg/day</td>
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<tr>
<td>Cometriq® (cabozantinib)</td>
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</table>

**EC systemic therapies:**
- carboplatin/paclitaxel, cisplatin/docetaxel, cisplatin/doxorubicin, carboplatin/paclitaxel/bevacizumab, carboplatin/paclitaxel/trastuzumab, ifosfamide/paclitaxel, cisplatin/ifosfamide, everolimus/letrozole, temsirolimus, Keytruda (pembrolizumab)

**ATC systemic therapies for metastatic disease:**
- dabrafenib/trametinib, larotrectinib, entrectinib, selpercatinib, paclitaxel/carboplatin, doxetaxel/doxorubicin, paclitaxel, doxorubicin

*Monotherapy treatment of combination regimens may also be used (refer to NCCN Uterine Neoplasms Guidelines)

**ATC: varies**

**Varies**

*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

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTC</td>
<td>24 mg PO QD</td>
<td>24 mg/day</td>
</tr>
<tr>
<td>EC</td>
<td>20 mg PO QD</td>
<td>20 mg/day</td>
</tr>
<tr>
<td>RCC</td>
<td>18 mg PO QD</td>
<td>18 mg/day</td>
</tr>
</tbody>
</table>
## Indication | Dosing Regimen | Maximum Dose
--- | --- | ---
HCC | 12 mg PO QD (if actual body weight ≥ 60 kg) or 8 mg PO QD (if actual body weight < 60 kg) | 12 mg/day

### VI. Product Availability
Capsules: 4 mg, 10 mg

### VII. References

### Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>New policy created: adapted from Commercial (CP.CPA.251) and HIM (HIM.PA.SP50) lines of business; new for Medicaid; age, specialist involvement in care and continuation of care added; two RCC prior therapy trials consolidated into one and only if clear cell or unknown histology - additional trial drugs added (Tarceva, Yervoy) for a total of 11; references reviewed and updated. Criteria added for new indication: unresectable HCC; references reviewed and updated.</td>
<td>09.04.18</td>
<td>11.18</td>
</tr>
<tr>
<td>4Q 2019 annual review: NCCN designation of recurrent added to MTC criteria; criteria added for new FDA indication in EC; references reviewed and updated.</td>
<td>10.15.19</td>
<td>11.19</td>
</tr>
<tr>
<td>4Q 2020 annual review: added off-label criteria for ATC per NCCN category 2A recommendation; references reviewed and updated.</td>
<td>07.13.20</td>
<td>11.20</td>
</tr>
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</table>

### 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.