Clinical Policy: Lenvatinib (Lenvima)
Reference Number: CP.PHAR.138
Effective Date: 12.01.18
Last Review Date: 11.19
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 Thyroid Carcinoma (off-label) (must meet all):
1. Diagnosis of medullary thyroid carcinoma (MTC);
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is recurrent, progressive, or metastatic;
5. Failure of Cometriq® or Caprelsa®, unless contraindicated or clinically significant adverse effects are experienced;  
   *Prior authorization may be required for Cometriq and Caprelsa.
6. 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. Will be used 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 contraindicated or clinically adverse effects are experienced;  
   *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 hepatocellular carcinoma;
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 $\geq 18$ 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: 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 (actual body weight $\geq 60$ kg) or 8 mg (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*).

*Prescribed regimen must be FDA-approved or recommended by NCCN
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 or evidence of coverage documents.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   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: regimens vary</td>
<td>Varies</td>
</tr>
<tr>
<td>Avastin® (bevacizumab)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cabometyx® (cabozantinib)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inlyta® (axitinib)</td>
<td></td>
<td></td>
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<td>Nexavar® (sorafenib)</td>
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<td>Opdivo® (nivolumab)</td>
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<tr>
<td>Proleukin® (aldesleukin, rIL-2)</td>
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<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>Votrient® (pazopanib)</td>
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<tr>
<td>Yervoy® (ipilimumab)</td>
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### Therapeutic Alternatives

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>
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<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>
<tr>
<td>HCC</td>
<td>12 mg PO QD (if actual body weight ≥ 60 kg) or 8 mg PO QD (if actual body weight &lt; 60 kg)</td>
<td>12 mg/day</td>
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### VI. Product Availability

Capsule: 4 mg, 10 mg

### VII. References


**Reviews, Revisions, and Approvals**

<table>
<thead>
<tr>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<td>09.04.18</td>
<td>11.18</td>
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<tr>
<td>10.15.19</td>
<td>11.19</td>
</tr>
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</table>

**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.

4Q 2019 annual review: NCCN designation of recurrent added to MTC criteria; criteria added for new FDA indication in EC; references reviewed and updated.

**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.

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**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.

**For Health Insurance Marketplace members,** when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.

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