BlueCross BlueShield of Arizona
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PHARMACY COVERAGE GUIDELINES	**ORIGINAL EFFECTIVE DATE: 1/01/16**
SECTION: DRUGS	**LAST REVIEW DATE: 11/15/18**
	LAST CRITERIA REVISION DATE: 11/15/18
	ARCHIVE DATE:

VOTRIENT® (pazopanib) oral tablet

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

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Criteria:

- **Criteria for initial therapy:** Votrient (pazopanib) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Prescriber is an Oncologist

2. Individual is 18 years of age or older

3. A confirmed diagnosis of **ONE** of the following:
   - Advanced renal cell carcinoma (RCC) that has relapsed **or** is Stage IV and unresectable
   - Advanced soft tissue sarcoma (STS) in an individual who has received prior chemotherapy
     - Prior chemotherapy includes:
       - A doxorubicin combination regimen
       - A gemcitabine combination regimen
       - Ifosfamide-epirubicin-mesna
       - Single agent therapy with:
         - Dacarbazine
         - Doxorubicin or liposomal doxorubicin
         - Epirubicin
         - Eribulin
         - Gemcitabine
         - Ifosfamide
         - Temozolamide
         - Trabectedin
         - Vinorelbine
   - Other request for a specific oncologic direct treatment use that is found and listed in the National Comprehensive Cancer Network (NCCN) Guidelines with Categories of Evidence and Consensus of 1 and 2

4. **ALL** of the following baseline tests have been completed before initiation of treatment with continued monitoring as clinically appropriate:
   - Comprehensive metabolic panel
   - Electocardiogram
   - Left ventricular ejection fraction
   - Evaluation of blood pressure, and if needed is adequately controlled with medication
   - Pregnancy test in a woman of child bearing potential

5. Will not be used in an individual with severe hepatic impairment (Child-Pugh Class C)

6. Woman patient of child bearing potential should use effective contraception during and for at least 2 weeks after therapy

7. Woman patient who is breast feeding an infant or child should stop breast feeding during and for at least 2 weeks after therapy

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8. Male patient on Votrient, even if has had a vasectomy, with female partners of reproductive potential should use condoms during and for 2 weeks after final dose

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Votrient (pazopanib) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Individual continues to be seen by an Oncologist

2. Individual's condition has not worsened while on therapy
   - Worsening is defined as:
     - Disease progressed while on Votrient

3. Individual has been adherent with the medication

4. Individual has not developed any significant level 4 adverse drug effects that may exclude continued use:
   - Significant adverse effect such as:
     - Hepatic impairment
     - Cardiac failure
     - Hemorrhage
     - Arterial thromboembolic events
     - Reversible Posterior Leukoencephalopathy Syndrome
     - Hypertension and Hypertensive Crisis
     - Proteinuria, repeated episodes of a 24-hour urine protein of ≥ 3 grams
     - Interstitial lung disease
     - Thrombotic microangiopathy (TMA), hemolytic uremia syndrome (HUS), and thrombocytopenic purpura (TTP)

5. There are no significant interacting drugs

Renewal duration: 12 months

Description:

Votrient (pazopanib) is indicated for the treatment of patients with advanced renal cell carcinoma (RCC) and it is indicated for the treatment of patients with advanced soft tissue sarcoma (STS) who have received prior chemotherapy. The efficacy of Votrient (pazopanib) for the treatment of patients with adipocytic STS or gastrointestinal stromal tumors (GIST) has not been demonstrated.

Votrient (pazopanib) is a multi-tyrosine kinase inhibitor of vascular endothelial growth factor receptor (VEGFR)-1, VEGFR-2, VEGFR-3, platelet-derived growth factor receptor (PDGFR)-α and -β, fibroblast growth factor receptor (FGFR)-1 and -3, cytokine receptor (Kit), interleukin-2 receptor-inducible T-cell kinase (Itk), leukocyte-specific protein tyrosine kinase (Lck), and transmembrane glycoprotein receptor tyrosine kinase (c-Fms). In vitro,

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pazopanib inhibited ligand-induced autophosphorylation of VEGFR-2, Kit, and PDGFR-β receptors. In vivo, pazopanib inhibited VEGF-induced VEGFR-2 phosphorylation in mouse lungs, angiogenesis in a mouse model, and the growth of some human tumor xenografts in mice.

Definitions:

National Comprehensive Cancer Network (NCCN) version 1.2018 (Sep 7, 2017)
NCCN definitions:
Category 1:
Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate
Category 2A:
Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate
Category 2B:
Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate
Category 3:
Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate

Relapse or Stage IV and surgically unresectable RCC:
Predominant Clear Cell Histology:
First-line therapy: (alphabetical by category and preference)
Category 1:
Clinical trial, pazopanib (preferred), sunitinib (preferred), bevacizumab + interferon alpha-2b, temsirolimus (for poor prognosis)
Category 2A:
Axitinib, cabozantinib (for poor and intermediate risk groups), high-dose aldesleukin [when excellent performance status (PS) and normal organ function]

Subsequent therapy: (alphabetical by category and preference)
Category 1:
Clinical trial, cabozantinib (preferred), nivolumab (preferred), axitinib, lenvatinib + everolimus,
Category 2A:
Everolimus, pazopanib, sorafenib, sunitinib

Non-Clear Cell Histology:
Systemic therapy: (alphabetical by category and preference)
Category 1:
Temsirolimus (poor prognosis patients)
Category 2A:
Clinical trial (preferred), sunitinib (preferred), axitinib, bevacizumab, bevacizumab + erlotinib (for selected patients with advanced papillary RCC including HLRCC), bevacizumab + everolimus (for selected patients with advanced papillary RCC including HLRCC), cabozantinib, erlotinib, everolimus, lenvatinib + everolimus, nivolumab, pazopanib, sorafenib temsirolimus (for risk groups other than poor-prognosis patients)

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Resources:

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.

Votrient. Package Insert. Revised by manufacturer 4/2015. Accessed 09-04-2015.

Votrient. Package Insert. Revised by manufacturer 08/2016. Accessed 10-20-2016

NCCN Clinical Practice Guidelines in Oncology: Kidney cancer. Version 1.2018, Sep 7, 2017. https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf

UpToDate: Overview of the treatment of renal cell carcinoma. Current through Aug 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/overview-of-the-treatment-of-renal-cell-carcinoma?source=search_result&search=renal%20cell%20carcinoma&selectedTitle=2~150#H1056311611

UpToDate: The treatment approach to non-clear cell renal carcinoma. Current through Aug 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/the-treatment-approach-to-non-clear-cell-renal-carcinoma?source=search_result&search=renal%20cell%20carcinoma&selectedTitle=4~150

UpToDate: Anti-angiogenic and molecularly targeted therapy for advanced or metastatic clear-cell renal cell carcinoma. Current through Aug 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/anti-angiogenic-and-molecularly-targeted-therapy-for-advanced-or-metastatic-clear-cell-renal-cell-carcinoma?source=search_result&search=renal%20cell%20carcinoma&selectedTitle=8~150#H38

NCCN Clinical Practice Guidelines in Oncology: Soft tissue sarcoma. Version 1.2018, Oct 31, 2017. https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf

UpToDate: Systemic treatment of metastatic soft tissue sarcoma. Current through Oct 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/systemic-treatment-of-metastatic-soft-tissue-sarcoma?source=search_result&search=soft%20tissue%20sarcoma&selectedTitle=2~150

UpToDate: Clinical presentation, histopathology, diagnostic evaluation, and staging of soft tissue sarcoma. Current through Oct 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/clinical-presentation-histopathology-diagnostic-evaluation-and-staging-of-soft-tissue-sarcoma?source=search_result&search=soft%20tissue%20sarcoma&selectedTitle=1~150

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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information

Medication Name:	Strength:	Dosage Form:
Directions for Use:	Quantity: / Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. **What is the diagnosis? Please specify below.**

   ICD-10 Code: _____ **Diagnosis Description:** _____

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. **Are there any supporting labs or test results? Please specify below.**

Date	Test	Value

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Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form.

Incomplete forms or forms without the chart notes will be returned.

Office notes, labs, and medical testing relevant to the request that show medical justification are required.