Neighborhood Health Plan OF RHODE ISLAND™

New Century Health

Policy #UM ONC_1197
PROPRIETARY & CONFIDENTIAL

POLICY NUMBER UM ONC_1197	**SUBJECT** Sutent™ (sunitinib)		**DEPT/PROGRAM** UM Dept	**PAGE 1 OF 2**
DATES COMMITTEE REVIEWED 01/04/12, 04/11/12, 11/13/13, 03/06/15, 07/25/16, 06/28/17, 07/26/17, 07/19/18, 06/12/19, 12/11/19, 05/13/20	**APPROVAL DATE** May 13, 2020	**EFFECTIVE DATE** May 29, 2020	**COMMITTEE APPROVAL DATES** (latest version listed last) 01/04/12, 04/11/12, 11/13/13, 03/06/15, 07/25/16, 06/28/17, 07/26/17, 07/19/18, 06/12/19, 12/11/19, 05/13/20	
PRIMARY BUSINESS OWNER: UM **APPROVED BY:** Dr. Andrew Hertler		**COMMITTEE/BOARD APPROVAL** Utilization Management Committee		
URAC STANDARDS	**NCQA STANDARDS** UM 2		**ADDITIONAL AREAS OF IMPACT**	
CMS REQUIREMENTS	**STATE/FEDERAL REQUIREMENTS**		**APPLICABLE LINES OF BUSINESS** All	

I. PURPOSE

To define and describe the accepted indications for Sutent (sunitinib) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

New Century is responsible for processing all medication requests from network ordering providers. Medications not authorized by New Century may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

II. INDICATIONS FOR USE/INCLUSION CRITERIA

1. **PREFERRED MEDICATION GUIDANCE FOR INITIAL REQUEST:**
    a. When health plan Medicaid coverage provisions- including any applicable PDLs (Preferred Drug Lists)- conflict with the coverage provisions in this drug policy, health plan Medicaid coverage provisions take precedence per the **Preferred Drug Guidelines OR**
    b. When health plan Exchange coverage provisions- including any applicable PDLs (Preferred Drug Lists)- conflict with the coverage provisions in this drug policy, health plan Exchange coverage provisions take precedence per the **Preferred Drug Guidelines OR**
    c. For Health Plans that utilize NCH UM Oncology Clinical Policies as the initial clinical criteria, the **Preferred Drug Guidelines shall follow NCH L1 Pathways** when applicable, otherwise shall follow NCH drug policies **AND**
    d. Continuation requests of previously approved non-preferred medication are not subject to this provision **AND**
    e. When available, generic alternatives are preferred over brand-name drugs.
2. **Renal cell carcinoma (RCC)**
    a. **NOTE: The preferred tyrosine kinase inhibitor, per NCH policy and NCH pathway for advanced or metastatic RCC, is Cabometyx (cabozantinib) or Votrient (pazopanib). Please refer to the NCH Pathway document for the most recent recommended agents/regimens.**
    b. Sutent(sinitnib) may be used in members with Good Risk disease, for first line therapy, in members who are intolerant to or have a contraindication to the use of Votrient (pazopanib).
3. **Gastrointestinal stromal tumor (GIST)**
    a. Sutent (sunitinib) will be used as a single agent in members who have disease progression on OR, contraindications to, OR intolerance to Imatinib.

4. **Pancreatic Neuroendocrine tumor (PNET)**
    a. **NOTE: The preferred agents, per NCH Policy and pathway, for first line and subsequent treatment of pancreatic neuroendocrine tumor are Everolimus and Sunitinib.**
    b. Sutent (sunitinib) will be used as a single agent for unresectable or metastatic pancreatic neuroendocrine tumor.

III. EXCLUSION CRITERIA

1. Off-label indications for Sutent (sunitinib) in soft tissue sarcoma and thyroid carcinoma.
2. Disease progression while receiving Sutent (sunitinib).
3. Concurrent use with other chemotherapy.
4. Dosing exceeds single dose limit of Sutent (sunitinib) 50 mg.
5. Treatment with Sutent (sunitinib) exceeds the maximum duration limit of 120 (12.5mg), 60 (25mg), and 30 (50 mg) capsules a month. For adjuvant therapy: do not exceed nine 6- week cycles.
6. Indications not supported by CMS recognized compendia or acceptable peer reviewed literature.

IV. MEDICATION MANAGEMENT

Please refer to the FDA label/package insert for details regarding these topics.

V. APPROVAL AUTHORITY

1. Review – Utilization Management Department
2. Final Approval – Utilization Management Committee

VI. ATTACHMENTS

None

VII. REFERENCES

1. Sutent prescribing information**.** Pfizer Labs; New York, NY. 2019
2. Clinical Pharmacology Elsevier Gold Standard. 2020.
3. Micromedex® Healthcare Series: Thomson Micromedex, Greenwood Village, Co. 2020.
4. National Comprehensive Cancer Network. Cancer Guidelines and Drugs and Biologics Compendium. 2020.
5. AHFS Drug Information. American Society of Health-Systems Pharmacists or Wolters Kluwer Lexi-Drugs. Bethesda, MD. 2020.