PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Inlyta Prior Authorization Policy
- Inlyta® (axitinib tablets – Pfizer)

REVIEW DATE: 06/04/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Inlyta, a kinase inhibitor, is indicated for **advanced renal cell carcinoma**, in combination with Bavencio® (avelumab intravenous infusion) as first-line treatment; in combination with Keytruda® (pembrolizumab intravenous infusion) as first-line treatment; and as a single agent after failure of one prior systemic therapy.[1]

Guidelines

Inlyta is discussed in guidelines from the National Comprehensive Cancer Network (NCCN):

- **Kidney Cancer:** NCCN guidelines (version 3.2025 – January 9, 2025) for relapse or stage IV disease with clear cell histology recommend the following: Inlyta + Keytruda as a "preferred regimen" (category 1), Inlyta + Bavencio as one of the "Other Recommended Regimens" (category 2A), and single agent Inlyta as "Useful in Certain Circumstances" (category 2B). For subsequent therapy for clear cell histology, Inlyta monotherapy and Inlyta + Keytruda are

category 2A options, regardless of prior immunotherapy; Inlyta + Bavencio is a category 3 option. Single agent Inlyta is one of the systemic therapy options listed under "Useful in Certain Circumstances" for relapse or Stage IV renal cell carcinoma with non-clear cell histology (category 2A).[2]

- **Soft Tissue Sarcoma:** NCCN guidelines (version 1.2025 – May 2, 2025) recommend Inlyta in combination with Keytruda as a "Preferred" regimen for alveolar soft part sarcoma (category 2A).[3]
- **Thymomas and Thymic Carcinomas**: NCCN guidelines (version 2.2025 – May 19, 2025) recommend Inlyta + Bavencio as second-line systemic therapy for thymic carcinoma under "Other Recommended" regimens for recurrent, advanced, or metastatic disease.[5] Inlyta + Bavencio can also be used as first-line therapy in patients who cannot tolerate first-line regimens.
- **Thyroid Carcinoma:** For differentiated thyroid cancer subtypes, NCCN guidelines (version 1.2025 – March 27, 2025) have changed the naming of Hürthle cell neoplasm to oncocytic carcinoma. [4] The guidelines recommend Inlyta as one of the kinase inhibitors to be considered if clinical trials or other systemic therapies are not available or appropriate. This is for radioactive iodine (RAI)-refractory papillary or follicular carcinoma or for oncocytic carcinoma. The guidelines note that a majority of oncocytic carcinoma are non-iodine-avid.[all category 2A].

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Inlyta. All approvals are provided for the duration noted below.

- **Inlyta® (axitinib tablets - Pfizer)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Renal Cell Cancer.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has relapsed or advanced disease.

Other Uses with Supportive Evidence

2. **Soft Tissue Sarcoma.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has alveolar soft part sarcoma; AND
   C) The medication will be used in combination with Keytruda (pembrolizumab intravenous infusion).

3. **Thymic Carcinoma.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has tried at least one chemotherapy regimen; AND
   Note: Examples of a chemotherapy regimen include carboplatin plus paclitaxel, cisplatin, doxorubicin plus cyclophosphamide, cisplatin plus etoposide, carboplatin, paclitaxel, and Cyramza (ramucirumab intravenous infusion).
   C) The medication will be used in combination with Bavencio (avelumab intravenous infusion).

4. **Thyroid Carcinoma, Differentiated.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   Note: Differentiated thyroid carcinoma include papillary, follicular, and oncocytic carcinoma (formerly Hürthle cell carcinoma).
   A) Patient is ≥ 18 years of age; AND
   B) Patient meets ONE of the following (i or ii):
      i. Patient meets BOTH of the following (a and b):
         a. Patient has papillary or follicular thyroid carcinoma; AND
         b. The disease is refractory to radioactive iodine therapy; OR
      ii. Patient has oncocytic (formerly Hürthle cell) carcinoma.

CONDITIONS NOT COVERED

- **Inlyta® (axitinib tablets - Pfizer)**

is(are) considered not medically necessary for ANY other use(s); criteria will be updated as new published data are available.

REFERENCES

1. Inlyta® tablets [prescribing information]. New York, NY: Pfizer; July 2024.
2. The NCCN Kidney Cancer Clinical Practice Guidelines in Oncology (version 3.2025 – January 9, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on May 20, 2025.
3. The NCCN Soft Tissue Sarcoma Clinical Practice Guidelines in Oncology (version 1.2025 – May 2, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on May 20, 2025.
4. The NCCN Thyroid Carcinoma Clinical Practice Guidelines in Oncology (version 1.2025 – March 27, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on May 20, 2025.
5. The NCCN Thymomas and Thymic Carcinoma Clinical Practice Guidelines in Oncology (version 2.2025 – May 19, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed May 21, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Thyroid Carcinoma, Differentiated:** For examples of thyroid carcinoma, changed Hürthle cell carcinoma name to "oncocytic	06/07/2023

	carcinoma (formerly Hürthle cell carcinoma)" based on guideline changes. **Soft Tissue Sarcoma:** A requirement was added that the patient is ≥ 18 years of age.	
Annual Revision	No criteria changes	06/19/2024
Annual Revision	**Thymic Carcinoma**: New condition of approval and criteria were added under "Other Uses with Supportive Evidence". **Thyroid Carcinoma, Differentiated:** Moved Note listing the different types of differentiate thyroid carcinoma to be under the indication. Separated criteria such that radioactive iodine-refractory disease is applicable to only follicular or papillary carcinoma and not for oncocytic carcinoma.	06/04/2025