



PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Pazopanib Prior Authorization Policy

- Votrient® (pazopanib tablets – Novartis; generic)

REVIEW DATE: 06/18/2025

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

Pazopanib, a multi-tyrosine kinase inhibitor, is indicated in adults for the following uses:¹

- **Renal cell carcinoma**, advanced.
- **Soft tissue sarcoma**, advanced, for patients who have received prior chemotherapy.

Guidelines

Pazopanib is discussed in guidelines from the National Comprehensive Cancer Network (NCCN)²:

- **Bone Cancer:** NCCN guidelines (version 2.2025 – February 28, 2025) recommend pazopanib as a systemic therapy agent as "other recommended" regimens for chondrosarcoma for metastatic and widespread disease (category 2A).³

- **Gastrointestinal Stromal Tumor (GIST):** NCCN guidelines (version 1.2025 – April 17, 2025) recommend pazopanib as an additional option after failure on approved therapies as “useful in certain circumstances” (category 2A).⁴ The first line therapy is imatinib; second-line therapy is sunitinib; third-line therapy is Stivarga® (regorafenib tablets); and fourth-line therapy is Qinlock® (ripretinib tablets). The guidelines also state in a footnote that for unresectable disease, sunitinib, Stivarga, and pazopanib are special considerations for succinate dehydrogenase (SDH)-deficient GIST (category 2A).⁴
- **Kidney Cancer:** NCCN guidelines (version 3.2025 – January 9, 2025) recommend pazopanib as first-line and subsequent therapy for relapsed or stage IV disease for clear cell histology (category 2A).⁵ Pazopanib is also recommended as a single-agent therapy for von Hippel-Lindau-associated renal cell carcinoma as useful in certain circumstances (category 2A).
- **Ovarian Cancer Including Fallopian Tube Cancer and Primary Peritoneal Cancer:** NCCN guidelines (version 2.2025 – May 23, 2024) recommend pazopanib (category 2B) as single-agent therapy for persistent disease or recurrence.⁶
- **Soft Tissue Sarcoma:** NCCN guidelines (version 1.2025 – May 2, 2025) recommend pazopanib as single agent therapy for alveolar soft part sarcoma, angiosarcoma, desmoid tumors (aggressive fibromatosis), extraskeletal myxoid chondrosarcoma, epithelioid hemangioendothelioma, and solitary fibrous tumor/hemangiopericytoma.⁷ Pazopanib is also recommended for dermatofibrosarcoma protuberans with fibrosarcomatous transformation for patients who are ineligible for intravenous systemic therapy or patients who are not candidates for anthracyclines-based regimens. For soft tissue sarcoma subtypes with non-specific histology, the guidelines recommend pazopanib as first-line therapy for advanced and metastatic for patients who are ineligible for intravenous systemic therapy or patients who are not candidates for anthracyclines-based regimens and as a subsequent line of therapy for advanced or metastatic disease as palliative therapy as a single-agent or in combination with gemcitabine (category 2A).
- **Thyroid Carcinoma:** NCCN guidelines (version 1.2025 – March 27, 2025) for differentiated thyroid carcinoma recommend pazopanib (category 2A) for progressive and/or symptomatic disease for unresectable locoregional recurrent or persistent disease not amenable to radioactive iodine therapy (for papillary and follicular types) or distant metastatic disease not amendable to radioactive iodine therapy.⁸ For differentiated thyroid cancer subtypes, the guidelines have changed the naming of Hürthle cell neoplasm to oncocytic carcinoma. A majority of oncocytic carcinoma are non-iodine-avid. Pazopanib can be considered for treatment of progressive or symptomatic medullary thyroid disease if clinical trials or preferred systemic therapy options are not available or appropriate, or if there is progression on preferred systemic therapy options.
- **Uterine Neoplasms:** NCCN guidelines (version 3.2025 – March 7, 2025) recommend pazopanib as a systemic therapy option for uterine sarcoma as “other recommended regimen” for patients with recurrent or metastatic

disease that have progressed on prior cytotoxic chemotherapy (category 2A).⁹

POLICY STATEMENT

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

• **Votrient® (pazopanib tablets - Novartis; generic)**
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 Indications

- 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 meets ONE of the following (i or ii):
 - i.** Patient has relapsed or advanced disease; OR
 - ii.** Patient has von Hippel-Lindau disease.
- 2. Soft Tissue Sarcoma.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
 - A)** Patient is ≥ 18 years of age; AND
 - B)** Patient does not have gastrointestinal stromal tumor; AND
Note: If patient has gastrointestinal stromal tumor, see criteria 4 for gastrointestinal stromal tumor.
 - C)** Patient has advanced or metastatic disease; AND
 - D)** Patient has ONE of the following (i, ii, iii, iv, v, vi, vii, viii, ix, x, or xi):
 - i.** Alveolar soft part sarcoma; OR
 - ii.** Angiosarcoma; OR
 - iii.** Dedifferentiated chordoma; OR
 - iv.** Dedifferentiated liposarcoma; OR
 - v.** Desmoid tumors (aggressive fibromatosis); OR
 - vi.** Dermatofibrosarcoma protuberans with fibrosarcomatous transformation; OR
 - vii.** Epithelioid hemangioendothelioma; OR
 - viii.** Extraskelatal myxoid chondrosarcoma
 - ix.** Non-adipocytic sarcoma; OR
 - x.** Pleomorphic rhabdomyosarcoma; OR
 - xi.** Solitary fibrous tumor/hemangiopericytoma.

Other Uses with Supportive Evidence

- 3. Bone Cancer.** 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 chondrosarcoma; AND
- C)** Patient meets BOTH of the following (i and ii):
 - i.** Patient has metastatic disease; AND
 - ii.** According to the prescriber, patient has widespread disease.

4. Gastrointestinal Stromal Tumor. 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 meets ONE of the following (i or ii):
 - i.** Patient has succinate dehydrogenase (SDH)-deficient gastrointestinal stromal tumor; OR
 - ii.** Patient has tried ALL of the following (a, b, c, and d):
 - a)** imatinib; AND
 - b)** sunitinib; AND
 - c)** Stivarga (regorafenib tablets); AND
 - d)** Qinlock (ripretinib tablets).

5. Ovarian Cancer, Fallopian Tube, or Primary Peritoneal 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 persistent or recurrent disease.

6. Thyroid Carcinoma, Differentiated. Approve for 1 year if the patient meets BOTH of the following (A, and B):

Note: Examples of 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.

7. Thyroid Carcinoma, Medullary. 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 tried at least one systemic therapy.

Note: Examples of systemic therapy include Caprelsa (vandetanib tablets), Cometriq (cabozantinib capsules), Retevmo (selpercatinib capsules), and Gavreto (pralsetinib capsules).

8. Uterine Sarcoma. Approve for 1 year if the patient meets ALL of the following (A, B, and C):

Note: Examples of uterine sarcoma include endometrial stromal sarcoma, undifferentiated uterine sarcoma, or uterine leiomyosarcomas.

- A)** Patient is ≥ 18 years of age; AND
- B)** Patient has recurrent or metastatic disease; AND

C) Patient has tried at least one systemic regimen.

Note: Examples of a systemic regimen include one or more of the following: doxorubicin, docetaxel, gemcitabine, ifosfamide, dacarbazine, epirubicin, or vinorelbine.

CONDITIONS NOT COVERED

• **Votrient® (pazopanib tablets - Novartis; generic)**
is(are) considered not medically necessary for ANY other use(s); criteria will be updated as new published data are available.

REFERENCES

1. Votrient® tablets [prescribing information]. East Hanover, NJ: Novartis; January 2024.
2. The NCCN Drugs & Biologics Compendium. © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed on June 10, 2025. Search term: pazopanib.
3. The NCCN Bone Cancer Clinical Practice Guidelines in Oncology (version 2.2025 – February 28, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed June 10, 2025.
4. The NCCN Gastrointestinal Stromal Tumors Clinical Practice Guidelines in Oncology (version 1.2025 – April 17, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed June 10, 2025.
5. 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 June 10, 2025.
6. The NCCN Ovarian Cancer Including Fallopian Tube Cancer and Primary Peritoneal Cancer Clinical Practice Guidelines in Oncology (version 2.2025 – May 23, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed June 10, 2025.
7. 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 June 10, 2025.
8. 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 June 11, 2025.
9. The NCCN Uterine Neoplasms Clinical Practice Guidelines in Oncology (version 3.2025 – March 7, 2025). © 2025 National Comprehensive Cancer Network. Available at: <http://www.nccn.org>. Accessed June 11, 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 carcinoma (formerly Hürthle cell carcinoma)” based on guideline changes.	06/14/2023
Annual Revision	Generic Votrient is available. Changed filename from Votrient Prior Authorization Policy to Pazopanib Prior Authorization Policy. Also changed Votrient to pazopanib throughout the policy. No criteria changes.	06/26/2024
Annual Revision	Soft Tissue Sarcoma: Added dedifferentiated chordoma and liposarcoma, epithelioid hemangioendothelioma, and extraskeletal myxoid chondrosarcoma to the list of approvable subtypes.	06/18/2025

	<p>Gastrointestinal Stromal Tumor: Deleted Ayvakit and Sprycel as therapy options from criteria.</p> <p>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.</p>	
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