

Clinical Policy Title:	pazopanib
Policy Number:	RxA.559
Drug(s) Applied:	pazopanib
Original Policy Date:	03/06/2020
Last Review Date:	12/11/2025
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Renal Cell Carcinoma (RCC) (must meet all):

1. Diagnosis of RCC;
2. Disease is advanced (i.e., relapsed or stage IV [unresectable or metastatic]).

Approval Duration

All Lines of Business (except Medicare): 6 months

B. Soft Tissue Sarcoma (STS) (must meet all):

1. Diagnosis of STS;
2. Diagnosis meets one of the following (a, b, or c):
 - a. STS subtype is solitary fibrous tumor/hemangiopericytoma or alveolar soft part sarcoma;
 - b. If GIST subtype, failure of one or more of the following agents unless contraindicated or clinically significant adverse effects are experienced: imatinib, Sutent®, Stivarga®;
 - *Prior authorization is required for imatinib, Sutent®, and Stivarga®.
 - c. For all other STS subtypes, failure of prior chemotherapy unless contraindicated or clinically significant adverse effects are experienced.

Approval Duration

All Lines of Business (except Medicare): 6 months

C. Uterine Sarcoma (off-label) (must meet all):

1. Diagnosis of uterine sarcoma;
2. Disease is recurrent or metastatic;
3. Trial and failure of prior cytotoxic chemotherapy (hormonal therapies such as aromatase inhibitors are not considered cytotoxic).

Approval Duration

All Lines of Business (except Medicare): 6 months

D. Thyroid Carcinoma (off-label) (must meet all):

1. Diagnosis of thyroid carcinoma;
2. Disease is unresectable, advanced or metastatic;
3. If papillary, follicular, or Hurthle cell carcinoma, disease is progressive and/or symptomatic iodine-

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refractory;

4. Histology meets one of the following (a or b):
 - a. If papillary, follicular, or Hurthle cell carcinoma, failure of Lenvima® or Nexavar® unless contraindicated or clinically significant adverse effects are experienced; *
 - b. If medullary carcinoma, failure of Caprelsa® or Cabometyx® unless contraindicated or clinically significant adverse effects are experienced.
*Prior authorization is required for Lenvima®, Nexavar®, and Cabometyx®.

Approval Duration

All Lines of Business (except Medicare): 6 months

E. Bone Cancer (off-label) (must meet all):

1. Diagnosis of bone cancer;
2. Member has chondrosarcoma;
3. Member meets one of the following (a or b):
 - a. Metastatic disease at presentation;
 - b. Systemic recurrence of high grade (grade II or III), clear cell, or extracompartmental chondrosarcoma.

Approval Duration

All Lines of Business (except Medicare): 6 months

F. Ovarian Cancer (off-label) (must meet all):

1. Diagnosis of ovarian cancer (including epithelial fallopian tube and primary peritoneal cancer);
2. Used as single-agent therapy.

Approval Duration

All Lines of Business (except Medicare): 6 months

II. Continued Therapy Approval

A. All Indications in Section I (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

Approval Duration

All Lines of Business (except Medicare): 12 months

References

1. National Comprehensive Cancer Network. Kidney Cancer Version 1.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Accessed August 28, 2024.
2. National Comprehensive Cancer Network. Soft Tissue Sarcoma Version 2.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf. Accessed August 28, 2024.
3. National Comprehensive Cancer Network. Uterine Neoplasms Version 2.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/uterine.pdf. Accessed August 28, 2024.
4. National Comprehensive Cancer Network. Thyroid Carcinoma Version 4.2024. Available at: https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf. Accessed August 28, 2024.
5. National Comprehensive Cancer Network. Bone Cancer Version 1.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/bone.pdf. Accessed August 28, 2024.
6. National Comprehensive Cancer Network. Gastrointestinal Stromal Tumors (GIST) Version 1.2025. Available at

https://www.nccn.org/professionals/physician_gls/pdf/bone.pdf. Accessed August 28, 2024.

7. National Comprehensive Cancer Network. Ovarian cancer Version 3.2024. Available at:
https://www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf . Accessed August 28, 2024.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy was reviewed: <ol style="list-style-type: none"> Clinical policy title was updated as “pazopanib”. Line of business policy applies to all lines of business. Initial approval criteria updated with “Ovarian cancer info. added”. Continued therapy approval criteria II.A.1 was rephrased to “Member is currently receiving medication that has been authorized by RxAdvance..” References were reviewed and updated. 	09/23/2020	12/07/2020
Policy was reviewed: <ol style="list-style-type: none"> Initial approval criteria 1.E,” Ovarian cancer off label use” removed. It is 2B recommendation per NCCN. Initial Approval criteria I.B.4 updated to include "Member has advanced or metastatic disease" Initial Approval Criteria. I.D.2 updated to include criteria for differentiated thyroid carcinoma. Initial approval criteria 1.D.4 updated to remove Capresla from prior authorization required. Initial Approval criteria I.E.4 updated to include “Used as single-agent therapy for persistent disease or with recurrence” Initial Approval criteria I.F added to include off label indication “Bone Cancer”. References were reviewed and updated. 	10/05/2021	12/07/2021
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: <ol style="list-style-type: none"> Added generic pazopanib to Drug(s) Applied. Removed age restrictions. Removed prescriber restrictions. Removed dose restrictions. Updated Continued therapy approval with auto-approval based on lookback 	8/28/2024	9/13/2024

<p>functionality within the past 120 days.</p> <ol style="list-style-type: none"> 6. Removed reauthorization requirement for positive response to therapy. 7. Updated approval duration verbiage. 8. References were reviewed and updated. 		
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> 1. Removed Votrient® from drug applied section. 	12/05/2024	N/A
Policy reviewed.	12/11/2025	12/11/2025