MEDICATION POLICY

Generic Name: Axitinib

Therapeutic Class or Brand Name: Inlyta®

Applicable Drugs (if Therapeutic Class)**:** N/A

Date of Origin: 2/1/13 **Date Last Reviewed/Revised:** 10/5/16

GPI Code: 2153400800

Prior Authorization Criteria (may be considered medically necessary when criteria I through IV are met):

I. Documented diagnosis of renal cell carcinoma (RCC).
II. Prior therapy with sunitinib (Sutent®) was ineffective, contraindicated, or not tolerated.
III. Minimum age requirement: 18 years old.
IV. Prescriber is an oncologist.

Exclusion Criteria:

- N/A

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

- Doses are limited to 10mg twice a day. The quantity is limited to a maximum of a 30 day supply per fill.

Approval Length:

- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

Appendix:

N/A

References:

1. http://blue.regence.com/trgmedpol/drugs/dru273.pdf.

Disclaimer: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgment in providing the most appropriate care for their patients.

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2. Medi-Span.

3. http://labeling.pfizer.com/ShowLabeling.aspx?id=759.

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Historical Tracking Of Changes Made To Policy	
10/5/2016	1. Policy reviewed: no changes made.
4/14/2015	1. **Changed** "Documentation diagnosis of renal cell carcinoma (RCC)" **to** "Documented diagnosis of renal cell carcinoma (RCC)" **under Prior Authorization Criteria**.
12/28/2013	1. **Adapted policy to new format.** 2. **Added GPI code**. 3. **Updated references** to include Medi-Span.