Clinical Policy: Axitinib (Inlyta)

Reference Number: CP.PHAR.100
Effective Date: 05.01.12
Last Review Date: 02.26
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Axitinib (Inlyta®) is a kinase inhibitor.

FDA Approved Indication(s)

Inlyta is indicated:

- In combination with avelumab, for the first-line treatment of patients with advanced renal cell carcinoma (RCC).
- In combination with pembrolizumab, for the first-line treatment of patients with advanced RCC.
- As a single agent, for the treatment of advanced RCC after failure of one prior systemic therapy.

Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Inlyta is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Renal Cell Carcinoma (must meet all):

1. Diagnosis of relapsed, metastatic, or stage IV RCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For Inlyta requests, member must use axitinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. Prescribed in one of the following ways (a or b):
   a. As single-agent therapy;
   b. For clear cell histology, in combination with Keytruda® or Bavencio®;*
   **Prior authorization may be required*
6. Request does not exceed health plan-approved quantity limit, if applicable;
7. Request meets one of the following (a or b):*
   a. Dose does not exceed both of the following (i and ii):
      i. 20 mg per day;
      ii. 4 tablets per day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).
   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

B. NCCN Compendium Indications (off-label) (must meet all)**:**
1. Diagnosis of one of the following (a, b, c, or d):
   a. Differentiated thyroid carcinoma (DTC; i.e., follicular, oncocytic [formerly known as Hurthle cell], or papillary thyroid carcinoma), and disease is both of the following (i and ii):
      i. Unresectable locoregional recurrent, persistent, or metastatic;
      ii. Progressive and/or symptomatic;
   b. Alveolar soft part sarcoma, and Inlyta is prescribed in combination with Keytruda*;
   c. Thymic carcinoma;
   d. Endometrial carcinoma that is recurrent;
   ** Prior authorization may be required*
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For Inlyta requests, member must use axitinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
5. For follicular and papillary thyroid carcinoma: Disease is refractory to radioactive iodine therapy;
6. For DTC: Clinical trials or other systemic therapies are not available or appropriate (*see Appendix B*);*
   **Prior authorization may be required*
7. For thymic carcinoma: Inlyta is prescribed in combination with Bavencio* and one of the following (a or b):
   a. Prescribed as second-line systemic therapy;
   b. Prescribed as first-line systemic therapy if member cannot tolerate first-line combination regimens;
   ** Prior authorization may be required*
8. For endometrial carcinoma: Disease is mismatch repair proficient (pMMR) and both of the following (a and b):
   a. Member has had previous therapy;
   b. Inlyta is prescribed in combination with Bavencio*;
   ** Prior authorization may be required*
9. Request does not exceed health plan-approved quantity limit, if applicable;
10. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).*
    **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

C. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Inlyta for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Inlyta requests, member must use axitinib, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. Request does not exceed health plan-approved quantity limit, if applicable;
5. If request is for a dose increase, request meets one of the following (a or b):*
   a. New dose does not exceed both of the following (i and ii):
      i. 20 mg per day;
      ii. 4 tablets per day;
   b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use *(prescriber must submit supporting evidence)*.

   **Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business:

CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

DTC: differentiated thyroid carcinoma
FDA: Food and Drug Association
NCCN: National Comprehensive Cancer Network
pMMR: mismatch repair proficient
RCC: renal cell carcinoma

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
DTC		
Lenvima® (lenvatinib)	24 mg PO QD	24 mg/day
Nexavar® (sorafenib)	400 mg PO QD	400 mg/day
Cometriq® (cabozantinib)	140 mg PO QD	140 mg/day
Vitravki® (larotrectinib)	(NTRK gene fusion-positive): Adult and pediatric patients with body surface area ≥ 1.0 m^2: 100 mg PO BID	200 mg/day
Rozlytrek™ (entrectinib)	(NTRK gene fusion-positive): Adults: 600 mg PO QD Pediatrics (≥ 12 years of age) dosed by body surface area (BSA)	600 mg/day
Retevmo™ (selpercatinib)	(RET gene fusion-positive): Weight < 50 kg: 120 mg PO BID	See dosing regimen

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Weight ≥ 50 kg: 160 mg PO BID	
Gavreto™ (pralsetinib)	(RET gene fusion-positive): 400 mg PO QD	800 mg/day with coadministration of strong CYP3A inducers
Keytruda® (pembrolizumab)	(Tumor mutational burden-high, MSI-H or dMMR tumors): 200 mg IV every 3 weeks OR 400 mg every 6 weeks up to 24 months	See dosing regimen
Thymic Carcinoma		
Examples of preferred regimens: carboplatin/paclitaxel/Cyramza® (ramucirumab), cisplatin/doxorubicin/ cyclophosphamide (CAP)	Varies	Varies
Endometrial Carcinoma		
Examples of preferred regimens: carboplatin/paclitaxel ± Keytruda® (pembrolizumab), Jemperli™ (dostarlimab-gxly), or trastuzumab	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
RCC	Single-agent therapy • 5 mg PO BID Combination therapy: • 5 mg PO BID with avelumab 800 mg every 2 weeks. • 5 mg PO BID with pembrolizumab 200 mg every 3 weeks or 400 mg every 6 weeks.	20 mg/day

VI. Product Availability

Tablets: 1 mg, 5 mg

VII. References

1. Inlyta Prescribing Information. New York, NY: Pfizer Labs, Inc.; July 2024. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/202324s016lbl.pdf. Accessed October 23,2025.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at: https://www.nccn.org/professionals/drug_compendium/content/. Accessed November 29, 2025.
3. National Comprehensive Cancer Network Guidelines. Kidney Cancer Version 1.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Accessed November 29, 2025.
4. National Comprehensive Cancer Network Guidelines. Thymomas and Thymic Carcinomas Version 1.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/thymic.pdf. Accessed November 29, 2025.
5. National Comprehensive Cancer Network Guidelines. Thyroid Carcinoma Version 1.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf. Accessed November 29, 2025.
6. National Comprehensive Cancer Network Guidelines. Endometrial Carcinoma Version 2.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/uterine.pdf. Accessed November 29, 2025.
7. Clinical Pharmacology [database online]. Philadelphia, PA: Elsevier. Updated periodically. Accessed November 29, 2025.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: no significant changes; clarified oral oncology generic redirection language to “must use”; references reviewed and updated.	11.09.21	02.22
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	01.20.22	05.22
Template changes applied to other diagnoses/indications.	09.29.22	
1Q 2023 annual review: Per NCCN Compendium for thyroid carcinoma added requirement that disease is not amenable to radioactive iodine therapy, added off-label indication of alveolar soft part sarcoma; references reviewed and updated.	10.24.22	02.23
1Q 2024 annual review: Per NCCN: for thyroid carcinomas, revised “Hurthle cell” to “oncocytic” per updated terminology, added criterion that disease is progressive and/or symptomatic, replaced criterion for failure of Lenvima or Nexavar with requirement that clinical trials or other systemic therapies are not available or appropriate; references reviewed and updated.	10.17.23	02.24
1Q 2025 annual review: collapsed off-label indications of thyroid carcinoma and soft tissue sarcoma under one off-label section; per	10.31.24	02.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
NCCN Compendium added indication of thymic carcinoma; references reviewed and updated.		
1Q 2026 annual review: for DTC, removed requirement for radioactive iodine therapy for oncocytic carcinoma and revised status from "not amenable" to "refractory" per NCCN; added off-label indication of endometrial carcinoma per NCCN; revised initial approval durations for Medicaid/HIM to 12 months; added request does not exceed health plan-approved quantity limit, if applicable; references reviewed and updated.	10.23.25	02.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible

for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.