Clinical Policy: Sunitinib (Sutent)

Reference Number: CP.PHAR.73
Effective Date: 09.01.11
Last Review Date: 05.26
Line of Business: Commercial, HIM/ICHRA, Medicaid

Revision Log

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

Description

Sunitinib (Sutent®) is a kinase inhibitor.

FDA Approved Indication(s)

Sutent is indicated in the treatment of adults with:

- Gastrointestinal stromal tumor (GIST) after disease progression on or intolerance to imatinib mesylate
- Advanced renal cell carcinoma (RCC)
- High risk of recurrent RCC following nephrectomy as adjuvant treatment
- Progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) with unresectable locally advanced or metastatic disease

Policy/Criteria

Provider must submit documentation (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 sunitinib and Sutent are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Gastrointestinal Stromal Tumor (must meet all)**:**

1. Diagnosis of GIST;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed in one of the following ways (a or b):
   a. As a single agent, and one of the following (i or ii):
      i. Disease progression on or intolerance to imatinib (Gleevec®);
      ii. Disease is succinate dehydrogenase (SDH)-deficient (off-label);
   b. In combination with everolimus (off-label), and all of the following (i, ii, and iii):
      i. Disease is gross residual (R2 resection), unresectable, tumor rupture, recurrent/progressive, or metastatic;
      ii. Disease is imatinib-sensitive, and one of the following (1 or 2):
         1) KIT mutant;
         2) PDGFRA mutant (except PDGFRA exon 18 mutant GIST that is insensitive to imatinib);
      iii. Member experienced disease progression on imatinib, sunitinib (as a single agent), Stivarga®, and Qinlock™;

**Prior authorization may be required for imatinib, sunitinib, Stivarga, and Qinlock.*

5. For Sutent requests, member must use generic sunitinib, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a, b, or c):*
   a. Dose does not exceed 50 mg per day - 4 weeks on/2 weeks off;
   b. If co-administered with a CYP3A4 inducer (e.g., dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifapentin, phenobarbital, St. John's Wort): Dose does not exceed 87.5 mg per day - 4 weeks on/2 weeks off;
   c. 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/ICHRA – 12 months
Commercial – 12 months or duration of request, whichever is less

B. Renal Cell Carcinoma (must meet all)**:**
1. Diagnosis of RCC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Sutent is requested for (a or b):
   a. Adjuvant therapy post-nephrectomy for clear cell histology for up to nine 6-week cycles of therapy (one 6-week cycle consists of 4 weeks on/2 weeks off);
   b. Treatment of relapsed or stage IV RCC;
5. For Sutent requests, member must use generic sunitinib, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a, b, or c):*
   a. Dose does not exceed 50 mg per day - 4 weeks on/2 weeks off;
   b. If co-administered with a CYP3A4 inducer (e.g., dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifapentin, phenobarbital, St. John's Wort): Dose does not exceed 87.5 mg per day - 4 weeks on/2 weeks off;
   c. 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/ICHRA – 12 months
Commercial – 12 months or duration of request, whichever is less

C. Pancreatic Neuroendocrine Tumor (must meet all)**:**
1. Diagnosis of well-differentiated pNET;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is unresectable, recurrent, advanced, or metastatic;
5. For Sutent requests, member must use generic sunitinib, unless contraindicated or clinically significant adverse effects are experienced;
6. Request meets one of the following (a. b, or c):*
   a. Dose does not exceed 37.5 mg per day;

b. If co-administered with a CYP3A4 inducer (e.g., dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifapentin, phenobarbital, St. John's Wort): Dose does not exceed or 62.5 mg per day;
c. 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/ICHRA – 12 months
Commercial – 12 months or duration of request, whichever is less

D. NCCN Compendium Indications (off-label) (must meet all)**:**

1. Diagnosis of one of the following (a-i):
   a. Chordoma for recurrent disease as a single agent;
   b. One of the following soft tissue sarcomas as a single agent (i, ii, iii, or iv):
      i. Angiosarcoma;
      ii. Solitary fibrous tumor;
      iii. Alveolar soft part sarcoma;
      iv. Extraskeletal myxoid chondrosarcoma;
   c. Thymic carcinoma as a single agent;
   d. Differentiated thyroid carcinoma (i.e., papillary carcinoma, follicular carcinoma, oncocytic (formerly known as Hurthle cell) carcinoma), and all of the following (i, ii, and iii):
      i. Disease is progressive and/or symptomatic unresectable locoregional recurrent, persistent, or distant metastatic;
      ii. Clinical trials or other systemic therapies (e.g., Lenvima®, Nexavar®, Cometriq®, Vitravki®, Rozlytrek™, Retevmo™, Keytruda®)* are not available or appropriate;
      **Prior authorization may be required.*
      iii. For papillary or follicular carcinoma, disease is refractory to radioactive iodine therapy;
   e. Medullary thyroid carcinoma for recurrent or persistent distant metastases if symptomatic disease or progression if clinical trials or preferred systemic therapy options (e.g., Caprelsa®, Cometriq®, Gavreto™, Retevmo™)* are not available or appropriate;
      **Prior authorization may be required.*
   f. Myeloid, lymphoid, or mixed phenotype neoplasms with eosinophilia and documentation of FLT3 rearrangement in chronic phase or blast phase;
   g. Pheochromocytoma/paraganglioma as treatment for secreting tumors as a single agent for locally unresectable disease or distant metastases;
   h. Meningioma for surgically inaccessible recurrent or progressive disease when radiation is not possible;
   i. Dedifferentiated chondrosarcoma as a single agent or in combination with nivolumab;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. For Sutent requests, member must use generic sunitinib, unless contraindicated or clinically significant adverse effects are experienced;

5. 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/ICHRA – 12 months
Commercial – 12 months or duration of request, whichever is less

E. 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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, 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 Sutent for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If receiving adjuvant therapy for RCC, member has not yet received nine 6-week cycles of therapy (one 6-week cycle consists of 4 weeks on/2 weeks off);
4. For Sutent requests, member must use generic sunitinib, unless contraindicated or clinically significant adverse effects are experienced;
5. If request is for a dose increase, request meets one of the following (a, b, or c)**:***
   a. GIST or RCC (i or ii):
      i. New dose does not exceed 50 mg per day - 4 weeks on/2 weeks off;
      ii. If co-administered with a CYP3A4 inducer (e.g., dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifapentin, phenobarbital, St. John's Wort): New dose does not exceed 87.5 mg per day - 4 weeks on/2 weeks off;
   b. pNET (i or ii):
      i. New dose does not exceed 37.5 mg per day;

ii. If co-administered with a CYP3A4 inducer (e.g., dexamethasone, phenytoin, carbamazepine, rifampin, rifabutin, rifapentin, phenobarbital, St. John's Wort): New dose does not exceed 62.5 mg per day;

c. Any indication: 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/ICHRA – 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/ICHRA) 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/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA, 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/ICHRA, 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/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
GIST: gastrointestinal stromal tumor
pNET: pancreatic neuroendocrine tumor
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 for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
imatinib mesylate (Gleevec®)	GIST: 400 mg/day up to 400 mg BID	800 mg/day
Qinlock (ripretinib)	GIST: 150 mg PO QD	150 mg/day
Stivarga® (regorafenib)	GIST: 160 mg PO QD for the first 21 days of each 28-day cycle	160 mg/day
Lenvima® (lenvatinib)	Differentiated thyroid carcinoma 24 mg PO QD	24 mg/day
Nexavar® (sorafenib)	Differentiated thyroid carcinoma 400 mg PO BID	800 mg/day
Caprelsa® (vandetanib)	Medullary thyroid carcinoma 300 mg PO QD	300 mg/day
Cometriq® (cabozantinib)	Medullary thyroid carcinoma 140 mg PO QD	140 mg/day
Vitravki® (larotrectinib)	Differentiated thyroid carcinoma (NTRK fusion-positive): Adult and pediatric patients with body surface area ≥ 1.0 m^2: 100 mg PO BID until disease progression or until unacceptable toxicity Pediatric patients with body surface area < 1.0 m2: 100 mg/m^2 PO BID until disease progression or until unacceptable toxicity	200 mg/day
Rozlytrek™ (entrectinib)	Differentiated thyroid carcinoma (NTRK fusion-positive): Adults: 600 mg PO QD Pediatrics (≥ 12 years of age) by body surface area (BSA): • BSA > 1.50 m2: 600 mg PO QD • BSA 1.11 to 1.50 m2: 500 mg PO QD • BSA 0.91 to 1.10 m2: 400 mg PO QD	600 mg/day
Retevmo™ (selpercatinib)	Thyroid carcinoma (RET-mutant or fusion positive) Weight < 50 kg: 120 mg PO BID Weight ≥ 50 kg: 160 mg PO BID	See dosing regimen
Keytruda® (pembrolizumab)	Differentiated thyroid carcinoma 200 mg IV every 3 weeks OR 400 mg every 6 weeks up to 24 months	See dosing regimen
Gavreto™ (pralsetinib)	Thyroid carcinoma (RET-mutant or fusion positive) 400 mg PO QD	800 mg/day with coadministration of strong CYP3A inducers

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

- Contraindication(s): none reported
- Boxed warning(s): hepatotoxicity

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
GIST	50 mg/day PO - 4 weeks/2 weeks off OR 87.5 mg/day PO - 4 weeks on/2 weeks off if co-administered with a CYP3A4 inducer.	87.5 mg/day
RCC	50 mg/day PO - 4 weeks/2 weeks off OR 87.5 mg/day PO - 4 weeks on/2 weeks off if co-administered with a CYP3A4 inducer. *(Limited to nine 6-week cycles in the adjuvant setting.)*	87.5 mg/day
pNET	37.5 mg/day PO OR 62.5 mg/day PO if coadministered with a CYP3A4 inducer.	62.5 mg/day

VI. Product Availability

Capsules: 12.5 mg, 25 mg, 37.5 mg, 50 mg

VII. References

1. Sutent Prescribing Information. New York, NY: Pfizer Inc.; October 2025. Available at: http://labeling.pfizer.com/ShowLabeling.aspx?id=607. Accessed January 23, 2026.
2. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at http://www.nccn.org/professionlas/drug_compendium. Accessed January 28, 2026.
3. National Comprehensive Cancer Network. Kidney Cancer Version 1.2026. Available at https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Accessed January 28, 2026.
4. National Comprehensive Cancer Network Guidelines. Gastrointestinal Stromal Tumors Version 1.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/gist.pdf. Accessed January 28, 2026.
5. National Comprehensive Cancer Network Guidelines. Bone Cancer Version 2.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/bone.pdf. Accessed January 28, 2026.
6. National Comprehensive Cancer Network Guidelines. Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes Version 1.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/mlne.pdf. Accessed January 28, 2026.
7. National Comprehensive Cancer Network Guidelines. Neuroendocrine and Adrenal Tumors Version 3.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/neuroendocrine.pdf. Accessed January 28, 2026.
8. National Comprehensive Cancer Network Guidelines. Soft Tissue Sarcoma Version 1.2026. Available at: https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf. Accessed January 28, 2026.

9. 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 January 28, 2026.
10. National Comprehensive Cancer Network Guidelines. Thyroid Carcinoma Version 1.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf. Accessed January 28, 2026.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2022 annual review: modified commercial approval duration from length of benefit to "12 months or duration of request, whichever is less"; WCG.CP.PHAR.73 to be retired and approval durations consolidated to 6 months; per NCCN added additional off-label uses in GIST for combination therapy with everolimus and SDH mutation positive disease, for GIST with disease progression or intolerance to imatinib clarified request is for single agent therapy, for differentiated and medullary thyroid carcinoma revised requirement of failure of two FDA approved therapies to more closely align with NCCN Compendium which recommends Sutent if clinical trials or other systemic therapies are not available or appropriate; for RCC initial authorization clarified in adjuvant therapy request is for up to nine cycles consistent with the current requirement for continuation of therapy; references reviewed and updated.	01.31.22	05.22
Template changes applied to other diagnoses/indications.	10.12.22	
2Q 2023 annual review: for RCC adjuvant therapy added clarification that clear cell histology is required per NCCN and prescribing information; for pNET added additional options for recurrent and advanced disease per NCCN; added pheochromocytoma/paraganglioma as NCCN supported off-label uses; references reviewed and updated.	01.06.23	05.23
2Q 2024 annual review: for myeloid/lymphoid neoplasms added requirement for use in the chronic or blast phase per NCCN Compendium; for GIST modified reference from 'SDH mutation positive' to 'SDH-deficient' per NCCN; for differentiated thyroid carcinoma clarified reference to oncocytic (formerly known as Hürthle cell) carcinoma per NCCN; references reviewed and updated.	01.22.24	05.24
2Q 2025 annual review: revised policy/criteria section to also include generic sunitinib; per NCCN, revised the following – for GIST, added tumor rupture as an acceptable qualifier; for pNET, added that tumor must be well-differentiated and removed requirement for use as a single agent; for off-label indications, added extraskeletal myxoid chondrosarcoma as a covered use and	02.05.25	05.25

Reviews, Revisions, and Approvals	Date	P&T Approval Date
updated myeloid/lymphoid neoplasms to include mixed phenotype; modified Medicaid/HIM continued approval duration from 6 months to 12 months per standard oncology approach; references reviewed and updated.		
2Q 2026 annual review: per NCCN, revised the following – for GIST, added requirement that disease is imatinib-sensitive KIT or PDGFRA mutant, added additional disease qualifier of gross residual (R2 resection) for combination therapy, and replaced requirement for use of Sprycel with Sutent prior to Sutent+everolimus combination therapy; for chordoma, thymic carcinoma, and soft tissue sarcoma, specified use a single agent; for differentiated thyroid carcinoma, modified requirement for radioactive iodine-refractory disease to apply only to papillary and follicular carcinomas; added off-label uses of meningioma and dedifferentiated chondrosarcoma; for Medicaid and HIM, extended initial approval duration from 6 to 12 months; references reviewed and updated. Added ICHRA line of business.	03.30.26	05.26

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.