I. Medication Description

Lenvima (lenvatinib) is a receptor tyrosine kinase (RTK) inhibitor that blocks the activities of vascular endothelial growth factor (VEGF) receptors and several other RTKs. Inhibition of these RTKs suppresses angiogenesis, tumor growth, and cancer progression.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

III. Policy

Coverage of Lenvima is available when the following criteria have been met:

- Member is at least 18 years of age AND
- The medication is prescribed by a hematologist/oncologist/urologist AND
- The requested use is supported by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines (NCCN Guidelines®) and/or NCCN Drugs & Biologics Compendium (NCCN Compendium®) with a recommendation of category level 1 or 2A.

IV. Quantity Limitations

Coverage is available for 1 box of 6 blister cards or 6 blister packs (maximum of 24 mg/day) for 30 days, unless dose modifications have occurred.

V. Coverage Duration

Coverage will be provided for 6 months and may be renewed.

VI. Coverage Renewal Criteria

Coverage can be renewed based upon the following criteria:

- Tumor response with stabilization of disease or decrease in size of tumor or tumor spread AND
- Absence of unacceptable toxicity from the drug

VII. Billing/Coding Information

- Available as blister packs containing varying quantities of 4mg and 10mg capsules to allow for daily doses of 8mg, 10mg, 14mg, 18mg, 20mg and 24mg.
VIII. Summary of Policy Changes

- 6/15/15: New policy
- 7/1/15: Formulary distinctions made
- 6/15/16: Updated coverage to coincide with current NCCN treatment guidelines
- 7/11/16: Updated policy to reflect current NCCN treatment guidelines
- 4/5/17: Updated policy to reflect current NCCN treatment guidelines
- 5/1/18: coverage criteria updated to allow use as supported by current NCCN guidelines
- 3/28/19: no policy changes

IX. References


The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

The preceding policy applies only to members for whom the above named pharmacy benefit medications are included on their covered formulary. Members with closed formulary benefits are subject to trying all appropriate formulary alternatives before a coverage exception for a non-formulary medication will be considered.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.