I. Medication Description

Sutent® (sunitinib) is a tyrosine kinase receptor inhibitor. Receptor tyrosine kinases are a group of enzymes that promote proliferation, metastasis and angiogenesis in cancer cells and tissues.

II. Position Statement

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

III. Policy

Coverage of Sutent 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 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 will be provided to accommodate FDA-approved dosing, up to 50 mg of Sutent per day (1500 mg per month)
- Increased quantities will require prior authorization review

V. Coverage Duration

Coverage is 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 12.5mg, 25mg, 37.5mg, and 50mg oral capsules

VIII. Summary of Policy Changes

• 1/1/12:
  o New criteria for pancreatic neuroendocrine tumor treatment coverage
  o Coverage criteria for soft tissue sarcoma and thyroid carcinoma added to policy
• 12/15/2012: Coverage criteria for lung neuroendocrine tumor added to policy
• 12/15/2013: Coverage criteria for bone cancer added to policy
• 1/1/15: addition of progression on Cometriq to thyroid carcinoma criteria
• 7/1/15: formulary distinctions made
• 12/15/15: coverage criteria added for thymomas and thymic carcinomas in accordance with current NCCN treatment guidelines
• 9/15/16: policy updated to correspond with current NCCN treatment guidelines
• 10/16/17: coverage criteria updated to allow use as supported by current NCCN guidelines
• 11/1/18: clarified quantity limits
• 11/15/19: no policy changes

IX. References

2. Up-To-Date, retrieved 7/2019.

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.