UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1357-5
Program	Prior Authorization/Notification
Medication	Fotivda® (tivozanib)
P&T Approval Date	5/2021, 5/2022, 5/2023, 5/2024, 5/2025
Effective Date	8/1/2025

1. Background:

Fotivda (tivozanib) is a kinase inhibitor indicated for the treatment of adult patients with relapsed or refractory advanced renal cell carcinoma (RCC) following two or more prior systemic therapies.

Coverage Information:
Members will be required to meet the criteria below for coverage. For members under the age of 19 years, the prescription will automatically process without a coverage review.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

2. Coverage Criteria[a]:

A. Patients less than 19 years of age

1. **Fotivda** will be approved based on the following criterion:

   a. Patient is less than 19 years of age

   Authorization will be issued for 12 months.

B. Renal Cell Carcinoma (RCC)

1. **Initial Authorization**

   a. **Fotivda** will be approved based on **all** of the following criteria:

      (1) Diagnosis of advanced renal cell carcinoma (RCC)

      -AND-

      (2) **One** of the following:

         (a) Disease has relapsed
         (b) Disease is refractory

      -AND-

(3) Patient has received two or more prior systemic therapies

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Fotivda** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Fotivda therapy

Authorization will be issued for 12 months.

C. NCCN Recommended Regimens

The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limit may be in place.

4. References:

1. Fotivda [package insert]. Boston, MA: AVEO Pharmaceuticals, Inc.; August 2024.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available at http://www.nccn.org/professionals/drug_compendium/content/contents.asp. Accessed April 9, 2025.

Program	Prior Authorization/Notification - Fotivda (tivozanib)
Change Control	
5/2021	New program.
5/2022	Annual review with no change to clinical criteria. Updated references.
5/2023	Annual review with no change to clinical criteria. Added state mandate footnote. Updated reference.
5/2024	Annual review with no change to clinical criteria. Updated references.

5/2025	Annual review with no change to clinical criteria. Updated references.