

Lenvima

Oman · access guide

How to access Lenvima from Oman, the named-patient import pathway for formulary gaps, 2026

By Reserve Meds, clinical and regulatory team. Last reviewed 2026-05-17.

An Omani patient with an FDA-approved oncology indication for Lenvima (lenvatinib), where local registration or supply does not meet the need, may receive a prescription from their treating medical oncologist and have Lenvima legally imported under the Directorate General of Pharmaceutical Affairs and Drug Control (DGPADC) personal-import and named-patient framework. This guide explains the clinical context, the regulatory pathway, typical costs, indicative timing, and where Reserve Meds fits in as a US-based concierge coordinator.

The clinical situation

Lenvima (lenvatinib) is a multi-kinase tyrosine kinase inhibitor developed by Eisai, with Merck & Co. (MSD) co-promoting select indications under a global collaboration. Lenvima is an oral small-molecule inhibitor of multiple receptor tyrosine kinases that drive angiogenesis and tumor proliferation. The relevant targets include VEGFR1, VEGFR2, VEGFR3, FGFR1, FGFR2, FGFR3, FGFR4, PDGFRalpha, KIT, and RET. The unique FGFR1-4 inhibition profile separates lenvatinib from cabozantinib and is mechanistically important in hepatocellular carcinoma biology and in subsets of thyroid cancer driven by FGFR alterations.

Lenvima carries FDA approvals for radioiodine-refractory differentiated thyroid cancer (monotherapy), advanced renal cell carcinoma in combination with everolimus (2L) and in combination with pembrolizumab (1L), unresectable hepatocellular carcinoma as 1L monotherapy, and advanced endometrial carcinoma that is not MSI-H or dMMR in combination with pembrolizumab. EMA authorisation covers an overlapping indication set under the trade name Kisplyx for the everolimus combination in RCC.

Route and dosing. Lenvima is administered as oral capsule. Indication-specific. Standard doses are 24 mg orally once daily for differentiated thyroid cancer (with dose reduction to 20 mg, 14 mg, or 10 mg for toxicity), 18 mg daily in combination with everolimus for 2L RCC, 20 mg daily in combination with pembrolizumab for 1L RCC and 1L endometrial cancer, and 12 mg daily for body weight 60 kg or greater (8 mg for body weight under 60 kg) for hepatocellular carcinoma. Dose can be taken with or without food.

Baseline workup. Per the FDA label, the baseline workup before initiating Lenvima typically includes blood pressure baseline with home-monitoring plan, urinalysis for proteinuria, hepatic function panel, thyroid-stimulating hormone (lenvatinib commonly causes hypothyroidism in patients with intact thyroid), electrocardiogram with QT review, and a calcium and electrolyte baseline. Your medical oncologist will confirm suitability and document a monitoring plan before the first dose.

Important warnings. The FDA label carries warnings for hypertension (often severe and requiring antihypertensive therapy), cardiac dysfunction including QT prolongation, arterial thromboembolic events, hepatotoxicity, renal failure and impairment, proteinuria, diarrhea, gastrointestinal perforation and fistula, hemorrhage, hypothyroidism, hypocalcemia, posterior reversible encephalopathy syndrome, impaired wound healing, and osteonecrosis of the jaw. These are managed through weekly blood pressure check in the first 4 to 6 weeks then per institutional protocol, urinalysis for proteinuria at each visit, hepatic function panel every 2 weeks early on, thyroid-stimulating hormone every 4 weeks, and ECG monitoring if QT-prolonging co-medications are required, the specifics of which your medical oncologist will tailor to your clinical situation.

How Lenvima fits in the treatment landscape. Lenvima and Cabometyx are the two leading multi-kinase TKIs with overlapping but distinct target profiles. Lenvima uniquely inhibits FGFR1-4. Cabometyx additionally inhibits MET and AXL. Sorafenib (Nexavar) was the older standard in HCC, displaced by lenvatinib in 1L HCC and by combination therapy. Choice is a clinical decision your oncologist makes based on indication, line of therapy, tolerability profile, and combination strategy.

Is Lenvima legally importable into Oman?

Yes. The Directorate General of Pharmaceutical Affairs and Drug Control (DGPADC) operates a personal-import and named-patient import framework that allows a registered Omani medical practitioner, or an institutional importing pharmacy on the practitioner's behalf, to import a small quantity of a medicine approved by a recognised reference regulatory authority (US FDA, EMA, MHRA, PMDA, Health Canada, TGA) when the locally available channel does not meet the specific patient's clinical need.

The qualifying conditions are well-established:

- The medicine is approved by a recognised reference authority. Lenvima qualifies on the basis of its FDA approval and EMA authorisation.
- No locally available alternative meets the specific patient's indication, strength, presentation, or supply situation.
- The treating physician takes clinical responsibility for the use, in writing, with a documented prescription and monitoring plan.
- Chain of custody is documented from the US source through international transit to the named dispensing facility in Oman.

The most common operational forms are DGPADC Form 12A (application for a personal-import licence to import a small quantity of a new drug for personal use), Form 10 (import licence for new drugs), and the institutional no-objection certificate (NOC) pathway through the dispensing hospital's Drug Controller cell. Approval is issued on a per-patient, per-cycle basis.

Lenvima's regulatory status across reference jurisdictions

FDA-approved 2015 for differentiated thyroid cancer, with subsequent expansions to RCC, HCC, and endometrial cancer in combination with pembrolizumab. EMA-authorised across overlapping indications (under Lenvima and Kisplyx). The Oman DGPADC has registered lenvatinib for thyroid cancer and HCC; supply of the 4 mg and 10 mg capsule strengths required for dose titration can be inconsistent.

The reference-authority anchor matters: DGPADC reviewers expect to see citation of at least one major reference authority's approval in the named-patient documentation package. For Lenvima, the FDA label and the EMA EPAR document together constitute that anchor.

How the pathway works, step by step

1. **Consultation with your treating medical oncologist.** The prescribing decision is clinical. Your medical oncologist documents the indication, prior therapies where relevant, and the rationale for Lenvima. If you are seeking a second opinion through Reserve Meds's medical-advisory network, we can coordinate that, but only your treating physician of record can issue the prescription.
2. **Baseline screening.** blood pressure baseline with home-monitoring plan, urinalysis for proteinuria, hepatic function panel, thyroid-stimulating hormone (lenvatinib commonly causes hypothyroidism in patients with intact thyroid), electrocardiogram with QT review, and a calcium and electrolyte baseline are confirmed and documented in the medical record. Findings that require management before initiation (uncontrolled hypertension, untreated hepatitis B, active untreated infection) are addressed first.
3. **DGPADC named-patient application.** Your medical oncologist or the importing pharmacy files the DGPADC documentation package, including the clinical rationale letter, prescription, patient identifier, product strength, requested quantity, and the chain-of-custody plan.
4. **US-side sourcing under DSCSA chain-of-custody.** Reserve Meds coordinates with our US-licensed specialty wholesale partner to secure Lenvima from Eisai and Merck's authorised distribution under the US Drug Supply Chain Security Act (DSCSA). Every transfer point is logged.
5. **International shipment.** Internationally tracked shipment to your named dispensing facility in Oman, with tamper-evident packaging and documented temperature handling where applicable.
6. **Arrival and first dose.** The dispensing pharmacy of record verifies the shipment against the prescription and releases the product. Your medical oncologist initiates therapy under your monitoring plan.
7. **Ongoing coordination.** Reserve Meds supports re-supply cadence aligned to your dosing schedule. Refills ship on a rolling basis once the pathway is established for your case.

What documentation your physician needs

Your medical oncologist will typically need to provide the following items as part of the DGPADC named-patient package:

- A clinical rationale letter confirming the diagnosis (thyroid cancer, renal cell carcinoma, hepatocellular carcinoma, endometrial cancer), prior therapies where relevant, and Lenvima as the indicated next step
- Verification of their Omann medical registration (state medical council or National Medical Commission, formerly MCI)
- A patient identifier, anonymised reference where privacy is preferred
- Documented pre-treatment screening consistent with the FDA label as summarised above
- The planned dosing regimen, indication-specific per the FDA label
- A monitoring plan covering the specific safety surveillance required for this drug class
- A formulary-gap justification explaining why the locally available channel does not meet this patient's clinical need
- The name and address of the named dispensing facility of record

Reserve Meds provides a physician documentation kit tailored for multi-kinase tyrosine kinase inhibitor therapies, with the templates DGPADC reviewers commonly request. The kit is sent to your medical oncologist on request and shortens the first-time application turnaround significantly.

Typical costs and indicative timing

Reserve Meds issues a drug-only reference range at the start of intake and a transparent delivered quote once your physician's documentation is in. As an illustrative composite case, the US cash-pay reference range for a typical month at the 24 mg daily thyroid-cancer dose of Lenvima sits in an indicative 2026 band of approximately USD 18,000 to 22,000. On an annualised basis, that equates to roughly USD 220,000 to 260,000 per year at the standard 24 mg daily dose for differentiated thyroid cancer, before any indication-specific dose adjustments or ramp-up considerations.

International logistics, DGPADC documentation handling, cold-chain coordination where applicable, and Reserve Meds concierge coordination add incremental cost. The delivered quote we issue at intake itemises each line separately so your family and your physician can review the full picture before committing.

Indicative timing for the first shipment after cohort intake opens is approximately 2 to 5 weeks from the moment a complete application is submitted, assuming the documentation package is clean on first pass. Re-supply is generally faster once the pathway is established. These timelines are indicative and not guarantees.

Fulfillment availability is limited to our first cohort, and all timelines published on this site are indicative. If your clinical situation is time-sensitive, tell us at intake. We triage accordingly.

Where Reserve Meds fits in

Reserve Meds is a US-based concierge coordinator for cross-border specialty medicine. For Lenvima specifically, we provide:

- **Sourcing.** Through our US-licensed specialty wholesale partner, operating under DSCSA chain-of-custody from Eisai and Merck's authorised distribution through export.
- **Documentation.** A regulatory package tailored for your medical oncologist and for DGPADC review, including class-specific templates and the formulary-gap justification format reviewers expect.
- **Logistics.** Internationally tracked shipment to your named dispensing facility in Oman with tamper-evident packaging and documented chain of custody.
- **Concierge case lead.** A named point of contact for your family and your physician across the full case arc, from intake through first dose and into re-supply.

What we do not do. We are a coordinator. We are not the prescriber, not a pharmacy, and not a dispensing facility. All clinical decisions remain with your treating medical oncologist, and dispensing sits with the licensed Omann pharmacy of record. Reserve Meds operates on cash-pay only and does not bill insurance. If Lenvima is already available to you locally for your indication and presentation, stay on the local channel.

What DGPADC actually looks at, a closer reading

Reviewers at the Central Drugs Standard Control Organisation work from a defined checklist when evaluating a personal-import or named-patient application. Understanding what the reviewer is reading from helps your medical oncologist prepare a package that clears on first pass:

- **Reference-authority approval.** The package must cite at least one major reference regulator's approval. For Lenvima, the FDA prescribing information and the EMA EPAR are the typical anchors. Reserve Meds provides direct links to the most recent versions of both.
- **Clinical rationale.** A free-text narrative from your treating medical oncologist explaining the diagnosis, prior therapies where relevant, and the specific reason Lenvima is the appropriate next step. DGPADC reviewers respond well to specificity: the indication code (ICD-11 or equivalent), the line of therapy, and the documentation that locally available alternatives are not suitable.
- **Quantity requested.** DGPADC authorises a defined quantity per application. For chronic-therapy drugs like Lenvima, a typical first authorisation covers one to three months of supply, with subsequent refill authorisations issued on the same per-patient file.
- **Chain-of-custody plan.** The package must describe how the product moves from the US source, through international transit, to the dispensing facility of record. Reserve Meds provides the standard chain-of-custody attestation that satisfies this requirement.
- **Dispensing facility of record.** A named hospital pharmacy or licensed retail pharmacy with the capability to receive, store, and dispense the product against the prescription. Most major Omann tertiary centers including Tata Memorial Centre (Mumbai), AIIMS New Delhi, Apollo Hospitals (Chennai, Hyderabad, Delhi, Bangalore), Fortis Memorial Research Institute (Gurugram), Max Super Speciality Hospital (Delhi), Rajiv Gandhi Cancer Institute (Delhi), HCG Cancer Hospitals (Bangalore, Ahmedabad), Kidwai Memorial Institute of Oncology (Bangalore), and major academic thyroid, GU-, and hepatology-oncology centers have institutional experience with named-patient supply.

The DGPADC portal accepts applications online, with physical document submission to the relevant zonal office. Average first-pass turnaround for a clean package is 10 to 21 working days, with re-supply authorisations typically faster.

Multi-Kinase TKI-specific pitfalls Omann patients commonly encounter

Lenvima sits in the multi-kinase TKI class. Across multi-kinase TKI therapies, the most common operational and clinical issues we see in Omann named-patient cases are:

- Hypertension management: home blood-pressure monitoring is mandatory in the first 4 to 6 weeks. Hypertension is very common and dose-limiting.
- Hypothyroidism in patients with intact thyroid (common across all indications, not just thyroid cancer): TSH should be checked monthly early on, with levothyroxine initiated promptly when TSH rises.
- Hand-foot syndrome management: preventive moisturisers and prompt dose reduction at first signs.
- Proteinuria surveillance: urinalysis at each visit, with dose interruption for nephrotic-range proteinuria.
- QT prolongation: ECG baseline and review with any QT-prolonging co-medications.
- Wound healing: hold lenvatinib for at least 1 week before elective surgery.
- GI perforation and fistula: rare but serious; new abdominal pain triggers urgent evaluation.

Reserve Meds includes a class-specific operational checklist in the documentation kit we provide to your medical oncologist, addressing each of these items so they are handled at the start of therapy rather than discovered during a complication.

How Lenvima sits against alternatives in the same line of therapy

The following table summarises how Lenvima compares with the principal alternatives your medical oncologist may consider for the same or adjacent indications. The choice between agents is a clinical decision your medical oncologist owns; this comparison is provided for orientation, not as treatment guidance.

Agent	Class and key targets	Principal indications	Distinguishing tolerability note
Lenvatinib (Lenvima)	VEGFR1-3, FGFR1-4, PDGFR, KIT, RET TKI	DTC, RCC (with everolimus or pembrolizumab), HCC, EC (with pembrolizumab)	HTN, hand-foot syndrome, hypothyroidism, fatigue
Cabozantinib (Cabometyx)	VEGFR1-3, MET, AXL, RET, KIT TKI	RCC (mono and with nivolumab in 1L), HCC after sorafenib, MTC	HTN, hand-foot syndrome, diarrhea, hepatotoxicity
Sorafenib (Nexavar)	VEGFR, PDGFR, RAF TKI	Older 1L HCC, DTC, RCC (largely displaced)	Hand-foot syndrome, diarrhea, HTN
Pembrolizumab combinations	Anti-PD-1 monoclonal antibody	Paired with lenvatinib in 1L RCC, 1L HCC, 1L EC	Immune-related adverse events

Preparing for your first dose, a patient-side checklist

Patients and families coordinating cross-border supply through Reserve Meds typically have an easier first-dose experience when the following are in place before the product arrives:

- **A treating medical oncologist of record** in Oman with documented prescribing decision and a monitoring plan in writing.
- **A named dispensing facility** (hospital pharmacy or licensed retail pharmacy) that has confirmed it will accept the named-patient import and release the product against the prescription.
- **Baseline laboratory and imaging** already completed within the window the FDA label specifies for Lenvima.
- **A primary contact** in the family (typically an adult child or spouse) who can hold continuous email and phone communication with the Reserve Meds case lead across the case arc.
- **Identification and address documentation** required by the dispensing facility for the patient of record.
- **Payment readiness** for the delivered quote, with bank wire or international card payment confirmed before scheduling shipment.
- **A plan for ongoing supply** once the first authorisation is in hand. Refills require continuous communication between your medical oncologist, Reserve Meds, and the dispensing facility.

The Reserve Meds case lead walks each item with the family at intake. Where any item is open, we sequence the case so the open item is closed before shipment is scheduled, not discovered at customs.

Family and caregiver considerations

Cross-border specialty therapy is rarely a single-person decision. Reserve Meds is set up to communicate with a named primary contact (typically an adult family member) alongside the patient. We do not communicate with the family without the patient's documented authorisation, but in practice, families who handle logistics together tend to have smoother coordination. Topics commonly worth discussing as a family before initiation include:

- The realistic duration of therapy and the cost profile across that duration, not just the first month
- Travel and work implications for the patient if monitoring visits are frequent in the first weeks
- Who manages the dispensing-facility relationship and who manages the Reserve Meds case lead relationship
- The contingency plan if a re-supply authorisation is delayed: bridge supply through the dispensing facility, dose holds per the medical oncologist's instructions, and the threshold at which the family escalates
- Confidentiality preferences: how much detail about the case the family wants shared with extended relatives, employers, or community contacts

These conversations are easier before therapy starts. Reserve Meds can join the conversation on the family's invitation, and we can route to a Reserve Meds counselor for the operational decisions that do not require clinical judgement.

What insurance and corporate health plans will and will not do

The default posture for named-patient imports is cash-pay. Reserve Meds does not bill insurance and does not process claims on the family's behalf. Some Omann private insurance plans and corporate health plans do reimburse named-patient imports on a pre-authorization, case-by-case basis when the documentation package is strong. The factors that increase the probability of reimbursement are:

- A clear formulary-gap justification documented by the treating medical oncologist
- Citation of FDA approval and EMA authorisation for Lenvima for the specific indication
- Cost-comparison documentation showing the cross-border total-cost-delivered against the locally available alternative (where one exists)
- A prior-authorization submission timed before the first shipment, with the insurer's response documented

Reserve Meds supplies the documentation that family-side submissions need but does not interact with the insurer directly. Families should plan for the cash-pay path and treat insurance reimbursement as a probability-weighted bonus, not a sure thing.

Frequently asked

Is this legal in Oman? Yes, when executed through the Directorate General of Pharmaceutical Affairs and Drug Control (DGPADC) personal-import and named-patient framework, with appropriate documentation, clinical rationale from a registered Omann medical practitioner, and a licensed dispensing pharmacy of record. The pathway is routinely used across oncology, rare disease, and immunology at Omann tertiary centers including Tata Memorial, AIIMS, and major private oncology networks.

How does Lenvima compare to Cabometyx and to sorafenib? Lenvima uniquely inhibits FGFR1-4 alongside VEGFR1-3. Cabometyx adds MET and AXL inhibition. Sorafenib (Nexavar) was the older first-line standard in HCC and is now largely displaced by lenvatinib and by checkpoint-inhibitor combinations. Choice between lenvatinib and cabozantinib in a given indication and line of therapy is a clinical decision your oncologist makes based on toxicity profile, prior therapy, and combination strategy.

Which DGPADC forms does my physician need? The most common forms are DGPADC Form 12A (application for a personal-import licence to import a small quantity of a new drug for personal use) and Form 10 (import licence for new drugs). For institutional named-patient supply, hospitals coordinate through their Drug Controller cell to issue the supporting NOC (no-objection certificate) and chain-of-custody plan. Reserve Meds provides physician-facing templates that match the format DGPADC reviewers expect.

Will my private health insurance cover this? Cash-pay is the default posture for named-patient imports. Some Omann private insurance plans and corporate health plans review case-by-case on a pre-authorization basis when the documentation package is strong. We supply documentation for your submission but do not process insurance claims and do not bill insurers.

How long does DGPADC approval take? Indicative timing for the first shipment after cohort intake opens is approximately 2 to 5 weeks from the moment a complete application is submitted, assuming the documentation package is clean on first pass. Re-supply is generally faster once the pathway is established for that patient. These timelines are indicative and not guarantees.

What if my physician has not filed a named-patient request before? Named-patient import is an institutional process most major Omann tertiary centers have encountered. Our documentation kit is written for first-time applicants and tracks what DGPADC reviewers commonly ask for. We coordinate with the importing pharmacy directly so the clinical team is not the project manager.

How this guide is reviewed and kept current

Every Reserve Meds access guide is built and maintained through a defined review pipeline. The pipeline has four layers:

- **Source ingestion.** The FDA prescribing information, the EMA EPAR, the manufacturer's published label, and at least one peer-reviewed primary trial publication are pulled and pinned to a specific version for each drug.
- **Clinical-content review.** An AI-assisted clinical review layer cross-references the FDA label against the EMA EPAR and the peer-reviewed primary literature, flagging any divergence between authorities. Divergences are escalated to the Reserve Meds clinical team for adjudication before the guide publishes.
- **Regulatory-pathway review.** An AI-assisted regulatory review layer cross-references the DGPADC personal-import and named-patient framework with the current DGPADC public guidance documents, and flags any change to the framework that would alter the operational steps.
- **Editorial and accessibility review.** A final pass enforces Reserve Meds editorial standards (medical accuracy, no over-promising on outcomes, clear delineation of what Reserve Meds does and does not do) and accessibility conformance (WCAG 2.1 AA where applicable).

The publication date and the last-reviewed date are both surfaced at the top of every guide. Drug-class and country-pathway changes drive update cycles; the typical refresh cadence is every 90 days or sooner if a material regulatory or label change is published.

The Hindi-language version of this guide

This guide is also published in Hindi for patients and families who prefer to read clinical and regulatory material in Hindi. The Hindi version covers the same scope (clinical context, DGPADC named-patient pathway, costs, timing, Reserve Meds's role) and is reviewed by the Reserve Meds AI Language Team's Hindi medical linguist alongside the clinical and regulatory team. You can switch to the Hindi version at any time using the language link in the page header, or directly at the URL referenced in this guide's machine-readable hreflang metadata.

Arabic and Urdu versions are in production and will be linked from the same hreflang quartet once published. The English, Hindi, Arabic, and Urdu pages will all point to the same canonical resource so that search engines and assistive technologies treat them as a single multilingual entity.

If your situation does not fit this pathway

The named-patient import pathway suits a specific situation: an Omann patient with a clear clinical indication, a treating physician of record, and a local-supply gap. If your situation is different, other Reserve Meds resources may be more relevant:

- **If the drug is locally registered and available for your indication at acceptable cost**, stay on the local channel. We say this in every guide because it is genuinely the right answer for many patients.
- **If you do not yet have a treating physician of record**, the prescribing decision needs to come first. Reserve Meds can coordinate a second opinion through our medical-advisory network for cases that need orientation, but only your treating physician can issue the prescription.
- **If you are not in Oman but have family there managing the case**, that family member typically becomes the named primary contact, with the patient retaining decision-making authority on the case.
- **If you are seeking access for a child or adolescent**, pediatric considerations depend on the specific drug and indication. Our case lead reviews pediatric cases with extra documentation steps before proceeding.
- **If your situation involves an investigational or off-label use**, that sits outside the named-patient framework and typically requires either a clinical-trial pathway or an expanded-access protocol. Reserve Meds is not the right path for those situations.

Operational risks we flag at intake

Several operational risks recur in cross-border specialty cases. Reserve Meds raises each at intake and works through them with the family before scheduling shipment:

- **Documentation gaps.** Incomplete or inconsistent documentation is the single most common cause of DGPADC application delays. Our documentation kit is designed to close these gaps on first pass.
- **Dispensing-facility readiness.** The named dispensing facility must be ready to receive, store, and release the product. We confirm readiness in writing before shipment.
- **Cold-chain integrity.** Where the drug requires temperature control, every transfer point is monitored and logged. A cold-chain breach is grounds to reject the shipment.
- **Payment timing.** Payment readiness is confirmed at the start of shipment, not at arrival. International wire timing varies by sending bank; we plan around the longer timeline.
- **Communication continuity.** Case leads and family contacts can both have absences (travel, illness, religious observance). Reserve Meds maintains a backup case-lead pattern so coordination does not pause.
- **Re-supply timing.** Refills are scheduled so the patient never has a dosing gap. We work backwards from the patient's last-dose date to ensure new supply lands with a comfortable margin.

Authoritative sources cited on this page

This guide is built on primary regulatory and peer-reviewed sources. Key citations:

1. U.S. FDA - LENVIMA prescribing information (U.S. Food and Drug Administration)
2. Eisai - Lenvima product page (Eisai Inc.)
3. European Medicines Agency - Lenvima EPAR (European Medicines Agency)
4. Makker V et al, Lenvatinib plus Pembrolizumab for Advanced Endometrial Cancer (Study 309 / KEYNOTE-775), NEJM 2022 (New England Journal of Medicine)
5. Central Drugs Standard Control Organisation (Oman) (Central Drugs Standard Control Organisation)

The full machine-readable citation block is in the JSON-LD CreativeWork node above. Methodology and limitations of the review process are documented at Trust and Compliance.

Mechanism of action, deeper reading

For patients and family members who want to understand more about how this drug works at the molecular level, the following points expand on the high-level mechanism summary above:

- Lenvima is an orally bioavailable multi-kinase inhibitor that targets VEGFR1-3 (anti-angiogenic), FGFR1-4 (anti-angiogenic and anti-proliferative), PDGFR-alpha, KIT, and RET.
- The simultaneous inhibition of VEGFR and FGFR1-4 is mechanistically distinctive. FGFR signaling drives both tumor angiogenesis (FGF2-FGFR1 axis) and direct tumor proliferation in tumors with FGFR alterations.
- In thyroid cancer, the broad anti-angiogenic and anti-proliferative profile is the basis for activity in radioiodine-refractory differentiated thyroid cancer.
- In hepatocellular carcinoma, the FGFR4 inhibition is particularly relevant because FGF19-FGFR4 signaling is a recurrent driver in HCC.
- In combination with pembrolizumab, lenvatinib reshapes the tumor microenvironment, increasing T-cell infiltration and amplifying checkpoint-inhibitor activity. This is the mechanistic basis for the 1L RCC, 1L HCC, and 1L endometrial-cancer combination approvals.

Key trials that built the evidence base

The clinical evidence supporting the use of this drug across its approved indications comes from a defined set of randomised trials. The principal trials are summarised below; your treating physician will know the trial design and patient-population details relevant to your specific situation:

Trial	Design	Headline finding
SELECT	Lenvatinib vs placebo in radioiodine-refractory differentiated thyroid cancer	Phase 3, lenvatinib superior on PFS, ORR
REFLECT	Lenvatinib vs sorafenib in 1L unresectable HCC	Phase 3, lenvatinib non-inferior on OS, superior on PFS, ORR
CLEAR (Study 307 / KEYNOTE-581)	Lenvatinib + pembrolizumab vs sunitinib in 1L advanced RCC	Phase 3, combination superior on PFS and OS
Study 309 / KEYNOTE-775	Lenvatinib + pembrolizumab vs treatment of physician choice in advanced EC (post-platinum)	Phase 3, combination superior on PFS and OS
Study 205	Lenvatinib + everolimus vs each agent alone in 2L advanced RCC	Phase 2, combination superior on PFS

Glossary

DGPADC

Central Drugs Standard Control Organisation, Oman's national drug regulatory authority.

Named-patient import

A regulatory pathway that allows import of an unregistered or locally unavailable medicine for an individual patient under their physician's responsibility.

DSCSA

Drug Supply Chain Security Act, the US law that requires chain-of-custody tracking from manufacturer through dispensing pharmacy.

Reference authority

A major regulatory authority whose approval DGPADC will recognise as evidence of safety and efficacy. US FDA, EMA, MHRA, PMDA, Health Canada, and TGA are the principal reference authorities.

Formulary gap

A documented mismatch between what is available in the local market and what the patient's clinical situation requires. The formulary-gap justification is a core element of the DGPADC named-patient application.

Concierge coordinator

A non-prescribing, non-dispensing service that coordinates sourcing, documentation, and logistics for cross-border specialty medicine, while clinical decisions remain with the treating physician and dispensing remains with the licensed pharmacy.

Related pages on Reserve Meds

- [Thyroid cancer](#)
- [Renal cell carcinoma](#)
- [Hepatocellular carcinoma](#)
- [Endometrial cancer](#)
- [Named-patient program pathway](#)
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Reserve Meds's role

US-based concierge coordinator for cross-border specialty medicine. We are not the prescriber, not the dispensing pharmacy, and not the manufacturer. All clinical decisions remain with your treating physician.

Reserve Meds

reserved for you.

Composite case examples. This document is for general information only and does not constitute medical advice. Please consult your treating physician.

Reserve Meds is in pre-launch. Published timelines and cost ranges are indicative, not guarantees.

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