Clinical Policy: Sorafenib (Nexavar)
Reference Number: ERX.SPA.13
Effective Date: 07.01.16
Last Review Date: 05.18

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

Description
Sorafenib (Nexavar®) is a kinase inhibitor.

FDA Approved Indication(s)
Nexavar is indicated:
- For the treatment of unresectable hepatocellular carcinoma (HCC)
- For the treatment of advanced renal cell carcinoma (RCC)
- For the treatment of locally recurrent or metastatic, progressive, differentiated thyroid carcinoma (DTC) refractory to radioactive iodine treatment

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 Envolve Pharmacy Solutions™ that Nexavar is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Hepatocellular Carcinoma (must meet all):
      1. Diagnosis of HCC;
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. Dose does not exceed 800 mg/day.
      Approval duration: Length of Benefit
   
   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. Dose does not exceed 800 mg/day.
      Approval duration: Length of Benefit

   C. Differentiated Thyroid Carcinoma (must meet all):
      1. Diagnosis of DTC (includes papillary, follicular, Hürthle cell carcinoma);
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. Disease is refractory to radioactive iodine treatment;
      5. Disease is locally recurrent or metastatic, and progressive;
      6. Dose does not exceed 800 mg/day.
      Approval duration: Length of Benefit

   D. Medullary Thyroid Carcinoma (off-label) (must meet all):
      1. Diagnosis of medullary thyroid carcinoma (MTC);
      2. Prescribed by or in consultation with an oncologist;
      3. Age ≥ 18 years;
      4. Member meets one of the following (a or b):
         a. Disease progression on vandetanib* or cabozantinib*, unless contraindicated or clinically significant adverse effects are experienced;
**Prior authorization is (or may be) required**

- Clinical trials are not available or appropriate;
- Dose is supported by practice guidelines or peer-reviewed literature (*prescriber must submit supporting evidence*).

**Approval duration: Length of Benefit**

### E. Acute Myeloid Leukemia (off-label) (must meet all):
1. Diagnosis of relapsed or refractory acute myeloid leukemia;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is FLT3-ITD mutation-positive;
5. Prescribed in combination with azacitidine or decitabine;
6. Dose is supported by practice guidelines or peer-reviewed literature (*prescriber must submit supporting evidence*).

**Approval duration: Length of Benefit**

### F. Bone Cancer (off-label) (must meet all):
1. Diagnosis of one of the following bone cancers (a or b):
   - Osteosarcoma, and Nexavar will be used for second-line therapy as a single agent or in combination with everolimus*;
   - Chordoma, and Nexavar will be used as single agent therapy for treatment of recurrent disease;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Dose is supported by practice guidelines or peer-reviewed literature (*prescriber must submit supporting evidence*).

**Approval duration: Length of Benefit**

### G. Soft Tissue Sarcoma (off-label) (must meet all):
1. Diagnosis of one of the following soft tissue sarcomas (a, b, c, or d):
   - Angiosarcoma as single-agent therapy;
   - Desmoid tumors (aggressive fibromatosis);
   - Solitary fibrous tumor/hemangiopericytoma as single-agent therapy;
   - Gastrointestinal stromal tumors (GIST) with disease progression after single-agent therapy with imatinib*, sunitinib*, or regorafenib*;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Dose is supported by practice guidelines or peer-reviewed literature (*prescriber must submit supporting evidence*).

**Approval duration: Length of Benefit**

### H. Other diagnoses/indications
1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

### II. Continued Therapy

#### A. All Indications in Section I (must meet all):
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or documentation supports that member is currently receiving Nexavar for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):
   - New dose does not exceed 800 mg/day;
b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Approval duration: Length of Benefit**

**B. Other diagnoses/indications** (must meet 1 or 2):
   1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
   **Approval duration: Duration of request or 6 months (whichever is less); or**
   2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

**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 policy – ERX.PA.01 or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

DTC: differentiated thyroid carcinoma  
MTC: medullary thyroid carcinoma  
HCC: hepatocellular carcinoma  
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 and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caprelsa® (vandetanib)</td>
<td>MTC: 300 mg PO QD</td>
<td>300 mg/day</td>
</tr>
<tr>
<td>Cometriq® (cabozantinib)</td>
<td>MTC: 140 mg PO QD</td>
<td>180 mg/day</td>
</tr>
<tr>
<td>imatinib (Gleevec®)</td>
<td>Soft Tissue Sarcoma: 400 mg PO QD</td>
<td>800 mg/day</td>
</tr>
<tr>
<td>Sutent® (sunitinib)</td>
<td>Soft Tissue Sarcoma: 37.5 to 50 mg PO QD</td>
<td>50 mg/day</td>
</tr>
<tr>
<td>Stivarga® (regorafenib)</td>
<td>Soft Tissue Sarcoma: 160 mg PO QD</td>
<td>160 mg/day</td>
</tr>
</tbody>
</table>

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: General Information*

- The NCCN Compendium includes sorafenib with a 2A recommendation in the following conditions: acute myeloid leukemia, bone cancer (chordoma, osteosarcoma), soft tissue sarcoma, and medullary thyroid carcinoma.

**V. Dosage and Administration**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC, RCC, thyroid cancer</td>
<td>400 mg orally twice daily</td>
<td>800 mg/day</td>
</tr>
</tbody>
</table>

**VI. Product Availability**

Tablet: 200 mg

**VII. References**


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created</td>
<td>05.16</td>
<td>06.16</td>
</tr>
<tr>
<td>Increased continued approval duration from 6 months to 12 months. Split NCCN off-label uses into their own criteria sets per updated template.</td>
<td>04.17</td>
<td>05.17</td>
</tr>
<tr>
<td>2Q 2018 annual review: added age; added NCCN compendium use for solitary fibrous tumor/hemangiopericytoma; summarized NCCN and FDA approved uses for improved clarity; added specialist involvement in care; added continuity of care statement; approval duration changed to length of benefit; references reviewed and updated.</td>
<td>01.17.18</td>
<td>05.18</td>
</tr>
</tbody>
</table>

**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.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.

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