

Clinical Policy: Sorafenib (Nexavar)

Reference Number: CP.PHAR.69

Effective Date: 07.01.11

Last Review Date: 05.20

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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 (sorafenib) is indicated for the treatment of:

- Unresectable hepatocellular carcinoma (HCC);
- Advanced renal cell carcinoma (RCC);
- Locally recurrent or metastatic, progressive, differentiated thyroid carcinoma (DTC) that is 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 Centene Corporation[®] 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 \geq 18 years;
4. Request meets one of the following (a or b):*
 - a. Dose does not exceed 800 mg per day;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid/HIM – 6 months

Commercial – 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 \geq 18 years;
4. Request meets one of the following (a or b):*
 - a. Dose does not exceed 800 mg per day;

- b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid/HIM – 6 months

Commercial – 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 \geq 18 years;
4. Disease is refractory to radioactive iodine treatment;
5. Disease is locally recurrent or metastatic, and progressive;
6. Request meets one of the following (a or b):*
 - a. Dose does not exceed 800 mg per day;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid/HIM – 6 months

Commercial – 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 \geq 18 years;
4. Member meets one of the following (a or b):
 - a. Disease progression on Caprelsa[®] or Cometriq[®], unless clinically significant adverse effects are experienced or both are contraindicated;
 - b. Clinical trials are not available or appropriate;
5. Request meets one of the following (a or b):*
 - a. Dose does not exceed 800 mg per day;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid/HIM – 6 months

Commercial – 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 \geq 18 years;
4. Disease is FLT3-ITD mutation-positive;
5. Prescribed in combination with azacitidine or decitabine;
6. Request meets one of the following (a or b):*

- a. Dose does not exceed 800 mg per day;
- b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid/HIM – 6 months

Commercial – Length of Benefit

F. Bone Cancer (off-label) (must meet all):

1. Diagnosis of one of the following bone cancers (a or b):
 - a. Osteosarcoma, and Nexavar will be used for second-line therapy as a single agent or in combination with Afinitor[®];
 - b. 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 \geq 18 years;
4. Request meets one of the following (a or b):*
 - a. Dose does not exceed 800 mg per day;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid/HIM – 6 months

Commercial – 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):
 - a. Angiosarcoma as single-agent therapy;
 - b. Desmoid Tumors (aggressive fibromatosis);
 - c. Solitary Fibrous Tumor/Hemangiopericytoma as single-agent therapy;
 - d. Gastrointestinal stromal tumors (GIST) with disease progression after single-agent therapy with imatinib, Sutent[®] or Stivarga[®];
2. Prescribed by or in consultation with an oncologist;
3. Age \geq 18 years;
4. Request meets one of the following (a or b):*
 - a. Dose does not exceed 800 mg per day;
 - b. Dose is supported by practice guidelines or peer-reviewed literature (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid/HIM – 6 months

Commercial – Length of Benefit

H. Ovarian Cancers (off-label) (must meet all):

1. Diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age \geq 18 years;

4. Disease is platinum-resistant (i.e., cancer returns less than 6 months after finishing platinum-based chemotherapy);
5. Disease is persistent or recurrent;
6. Prescribed in combination with topotecan;
7. Request meets one of the following (a or b):*
 - a. Dose does not exceed 800 mg per day;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid/HIM – 6 months

Commercial – Length of Benefit

I. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Currently receiving medication via Centene benefit 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):*
 - a. New dose does not exceed 800 mg per day;
 - b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid/HIM – 12 months

Commercial – Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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 policies –

CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

DTC: differentiated thyroid carcinoma
FDA: Food and Drug Administration
HCC: hepatocellular carcinoma

MTC: medullary thyroid 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 for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Caprelsa [®] (vandetanib)	MTC: 300 mg PO QD	300 mg/day
Cometriq [®] (cabozantinib)	MTC: 140 mg PO QD	180 mg/day
imatinib (Gleevec [®])	Soft Tissue Sarcoma: 400 mg PO QD	800 mg/day
Sutent [®] (sunitinib)	Soft Tissue Sarcoma: 37.5 to 50 mg PO QD	50 mg/day
Stivarga [®] (regorafenib)	Soft Tissue Sarcoma: 160 mg PO QD	160 mg/day

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: Contraindications/Boxed Warnings

- Contraindication(s):
 - Known severe hypersensitivity to sorafenib or any other component of Nexavar
 - Nexavar use in combination with carboplatin and paclitaxel in patients with squamous cell lung cancer
- Boxed warning(s): none reported

Appendix D: 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, thyroid carcinomas, and epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
HCC, RCC, thyroid cancer	400 mg PO BID	800 mg/day

VI. Product Availability

Tablet: 200 mg

VII. References

1. Nexavar Prescribing Information. Whippany, NJ: Bayer HealthCare Pharmaceuticals, Inc.; December 2018. Available at: http://labeling.bayerhealthcare.com/html/products/pi/Nexavar_PI.pdf. Accessed February 15, 2020.
2. National Comprehensive Cancer Network. Acute Myeloid Leukemia Version 3.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/aml.pdf. Accessed February 15, 2020.
3. National Comprehensive Cancer Network. Bone Cancer Version 1.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/bone.pdf. Accessed February 15, 2020.
4. National Comprehensive Cancer Network. Hepatobiliary Cancers Version 4.2019. Available at: https://www.nccn.org/professionals/physician_gls/pdf/hepatobiliary.pdf. Accessed February 15, 2020.
5. National Comprehensive Cancer Network. Kidney Cancer Version 2.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/kidney.pdf. Accessed February 15, 2020.
6. National Comprehensive Cancer Network. Soft Tissue Sarcoma Version 6.2019. Available at: https://www.nccn.org/professionals/physician_gls/pdf/sarcoma.pdf. Accessed February 15, 2020.
7. National Comprehensive Cancer Network. Thyroid Carcinoma Version 2.2019. Available at: https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf. Accessed February 15, 2020.
8. National Comprehensive Cancer Network. Ovarian Cancer Version 3.2019. Available at: https://www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf. Accessed February 15, 2020.
9. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at http://www.nccn.org/professionals/drug_compendium. Accessed February 15, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy converted to new template. Criteria: added contraindications per PI; added NCCN recommended uses, added maximum dose requirement.	05.16	06.16
Under hepatocellular cancer, “disease is unresectable” is broadened to include “or metastatic”. Under RCC, “relapse or surgically unresectable Stage IV disease” is changed to “relapsed or Stage IV disease.” Under thyroid carcinoma, 1) differentiated carcinoma is defined per the NCCN guidelines, 2) “disease locally recurrent or metastatic, and progressive” is changed to “disease is progressive or symptomatic, and recurrent or metastatic” 3) medullary thyroid carcinoma is added. Safety information removed. Chordoma is added under bone cancer per the NCCN compendium (Section I.D).	05.17	06.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2018 annual review: Added HIM line of business; 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; references reviewed and updated.	01.17.18	05.18
2Q 2019 annual review: no significant changes; added commercial line of business; references reviewed and updated.	02.26.19	05.19
2Q 2020 annual review: added NCCN compendium-supported indication of ovarian cancers; references reviewed and updated.	02.15.20	05.20

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. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. 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. This clinical policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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