Clinical Policy: Sorafenib (Nexavar)

Reference Number: CP.PHAR.69
Effective Date: 07.01.11
Last Review Date: 05.18
Line of Business: 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 a kinase inhibitor/oral tablet formulation indicated for the treatment of patients with:

- 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 ≥ 18 years;
4. Dose does not exceed 800 mg/day.

Approval duration: 6 months

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: 6 months

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: 6 months

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;
   b. Clinical trials are not available or appropriate;

   **Prior authorization is (or may be) required*
5. Dose is supported by practice guidelines or peer-reviewed literature (*prescriber must submit supporting evidence*).

Approval duration: 6 months

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: 6 months

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 everolimus*;
   b. Chordoma, and Nexavar will be used as single agent therapy for treatment of recurrent disease;

   **Prior authorization is (or may be) required*
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: 6 months

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*, sunitinib*, or regorafenib*;

**Prior authorization is (or may be) required*

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: 6 months

H. 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): 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 one of the covered indications 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. 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: 12 months

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): 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 – 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: General Information

- NCCN Compendium include 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

Indication	Dosing Regimen	Maximum Dose
HCC, RCC, thyroid cancer	400 mg orally twice daily	800 mg/day

VI. Product Availability

Tablet: 200 mg

VII. References

1. Nexavar Prescribing Information. Whippany, NJ: Bayer HealthCare Pharmaceuticals, Inc.; December 2017. Available at http://labeling.bayerhealthcare.com/html/products/pi/Nexavar_PI.pdf. Accessed January 10, 2018.
2. Sorafenib. In: National Comprehensive Cancer network Drug and Biologics Compendium. Available at ncccn.org. Accessed January 10, 2018.
3. Hepatobiliary cancers (Version 4.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed January 10, 2018.
4. Kidney cancer (Version 2.2018). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed January 10, 2018.
5. Thyroid carcinoma (Version 2.2017). In: National Comprehensive Cancer Network Guidelines. Available at nccn.org. Accessed January 10, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added Differentiated Thyroid Carcinoma Indication; modified safety information; and added references.	06.14	07.14
Updated DTC indication per package insert Edited studies to reflect those focusing on FDA-approved indications Added warning regarding exogenous thyroid suppression Added Appendices A (contraindications), B (adverse reactions for which permanent discontinuation is recommended) and C (adverse reactions and situations for which it is recommended that discontinuation be considered) The first two appendices are used in the algorithm Algorithm: changed question about levothyroxine to "is the cancer refractory to radioactive iodine treatment?"; added age requirement (for adults); added question about contraindications per Appendix A; added questions about adverse reactions per Appendix B	06.15	06.15
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
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

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.

 Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.