Clinical Policy Title:	sorafenib
Policy Number:	RxA.237
Drug(s) Applied:	Nexavar®
Original Policy Date:	02/07/2020
Last Review Date:	09/14/2021
Line of Business Policy Applies to:	All lines of business

Background

Sorafenib (Nexavar®) is a kinase inhibitor. It 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.

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
sorafenib (Nexavar®)	Hepatocellular carcinoma, renal cell carcinoma, thyroid cancer	400 mg orally twice a day	800 mg/day

Dosage Forms

- Tablet: 200 mg

Clinical Policy

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria. The provision of provider samples does not guarantee coverage under the terms of the pharmacy benefit administered by RxAdvance. All criteria for initial approval must be met in order to obtain coverage.

I. Initial Approval Criteria

A. Hepatocellular Carcinoma (must meet all):

1. Diagnosis of one of the following Child-Pugh Class A or B7 hepatocellular carcinoma (a, b, c or d);
   a. Unresectable disease and are not a transplant candidate;
   b. Inoperable by performance status or comorbidity;
   c. Local disease or local disease with minimal extrahepatic disease only;
   d. Metastatic disease or extensive liver tumor burden.
2. Prescribed by or in consultation with an oncologist;
3. Age 18 ≥ years;
4. Prescribed as single agent therapy;

5. Dose does not exceed 800 mg/day.

Approval Duration
Commercial: 12 months
Medicaid: 6 months

B. Renal Cell Carcinoma (must meet all):
1. Diagnosis of relapsed or stage IV renal cell carcinoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Prescribed as single agent therapy;
5. Dose does not exceed 800 mg/day.

Approval Duration
Commercial: 12 months
Medicaid: 6 months

C. Differentiated Thyroid Carcinoma (must meet all):
1. Diagnosis of DTC (includes Papillary,Follicular, Hürthle cell carcinoma) that is (a or b):
   a. Unresectable locoregional recurrent or persistent disease; or
   b. Distant metastatic disease;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Disease is refractory to radioactive iodine treatment;
5. Dose does not exceed 800 mg/day.

Approval Duration
Commercial: 12 months
Medicaid: 6 months

D. 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 ≥ 60 years;
4. Disease is FLT3-ITD mutation-positive;
5. Request is to be used as a component of repeating the initial successful induction regimen if late relapse (≥12 months since induction regimen) if not administered continuously and not stopped due to development of clinical resistance;
6. Prescribed in combination with azacitidine or decitabine;
7. Request meets one of the following (a or b):
   a. Dose does not exceed 800 mg/day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

Approval Duration
Commercial: 12 months
Medicaid: 6 months

E. Bone Cancer (off-label) (must meet all):
1. Diagnosis of one of the following bone cancers (a or b):
   a. Osteosarcoma, relapsed/refractory or metastatic disease, and sorafenib will be used for second-line therapy as a single agent or in combination with everolimus; or

b. Chordoma, and sorafenib 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. Request meets one of the following (a or b):
   a. Dose does not exceed 800 mg/day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

Approval Duration
Commercial: 12 months
Medicaid: 6 months

F. Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer (off-label) (must meet all):
1. Diagnosis of one of the following (a, b or c):
   a. Epithelial ovarian cancer;
   b. Fallopian tube cancer;
   c. Primary peritoneal cancer;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. If platinum-resistant, prescribed in combination with topotecan for persistent disease or recurrence;
5. Request meets on of the following (a or b):
   a. Dose does not exceed 800 mg/day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

Approval Duration
Commercial: 12 months
Medicaid: 6 months

G. Medullary Thyroid Carcinoma (off-label) (must meet all):
1. Diagnosis of recurrent or persistent distant metastatic 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 (Caprelsa®) or cabozantinib (Cometriq®), unless contraindicated or clinically significant adverse effects are experienced;
   b. Clinical trials are not available or appropriate;
   *Prior authorization may be required for vandetanib and/or cabozantinib
5. Request meets one of the following (a or b):
   a. Dose does not exceed 800 mg/day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

Approval Duration
Commercial: 12 months
Medicaid: 6 months.

H. Myeloid/Lymphoid Neoplasms with Eosinophilia and FLT3 rearrangement (off-label) (must meet all):
1. Diagnosis of myeloid/lymphoid neoplasm with eosinophilia and FLT3 rearrangement in blast or chronic phase;
2. Prescribed by or in consultation with an oncologist;

3. Age ≥ 18 years;
4. Request meets one of the following (a or b):
   a. Dose does not exceed 800 mg/day;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

Approval Duration
Commercial: 12 months
Medicaid: 6 months

I. 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) as single agent therapy for primary treatment or treatment of gross residual disease (R2 resection) in abdominal wall tumors if time to response is more critical as a single agent (preferred) for (meets one of the following i, ii, or iii):
      i. Ongoing progression with potential morbidity or significant symptoms in anatomic location where progression would not be morbid;
      ii. Documented progression in anatomic location where progression would be morbid;
      iii. No documented progression in anatomic location where progression would be morbid if concerns for morbidity or significant symptoms;
   c. Solitary Fibrous Tumor/Hemangiopericytoma as single agent therapy;
   d. Gastrointestinal stromal tumors (GIST), unresectable or metastatic disease progression after single-agent therapy with imatinib, sunitinib and regorafenib;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Request meets one of the following (a or b):
   a. Dose does not exceed 800 mg/day;
   b. Dose is supported by practice guidelines or peer-reviewed literature (prescriber must submit supporting evidence).

Approval Duration
Commercial: 12 months
Medicaid: 6 months

II. Continued Therapy Approval

A. All Indications in Section I (must meet all):
1. Member is currently receiving medication that has been authorized by RxAdvance or member has previously met initial approval criteria listed in this policy.
2. Member is currently receiving sorafenib for one of the covered indications and has received this medication for at least 30 days;
3. Member is responding positively to therapy (i.e., lack of disease progression);
4. 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
Commercial: 12 months
Medicaid: 12 months

III. Appendices

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
FLT3-ITD: fms-like tyrosine kinase 3 internal tandem duplication

APPENDIX B: Therapeutic Alternatives

Below are suggested therapeutic alternatives based on clinical guidance. Please check drug formulary for preferred agents and utilization management requirements.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
vandetanib (Caprelsa®)	MTC: 300 mg orally once daily	300 mg/day
Cometriq®	MTC: 140 mg orally once daily	180 mg/day
imatinib (Gleevec®)	Soft Tissue Sarcoma: 400 mg orally once daily	800 mg/day
Sutent®	Soft Tissue Sarcoma: 37.5 to 50 mg orally once daily	50 mg/day
Stivarga®	Soft Tissue Sarcoma: 160 mg orally once daily	160 mg/day

Therapeutic alternatives are listed as generic (Brand name®) when the drug is available by both generic and brand, Brand name® when the drug is available by brand only and generic name when the drug is available by generic only.

APPENDIX C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Known severe hypersensitivity to sorafenib or any other component of sorafenib.
  - Sorafenib use in combination with carboplatin and paclitaxel in patients with squamous cell lung cancer.

- Boxed Warning(s):
  - None reported.

APPENDIX D: General Information

- NCCN Compendium include sorafenib with a 2A recommendation in the following conditions: acute myeloid leukemia, bone cancer (chordoma, osteosarcoma), soft tissue sarcoma, myeloid/lymphoid neoplasms with eosinophilia and FLT3 rearrangement, ovarian cancer, fallopian tube cancer, primary peritoneal cancer, soft tissue sarcoma and medullary thyroid carcinoma.

References

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Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
Policy updated. 1. Formatting updated. 2. Criteria for approval and continued approval updated. 3. Approval duration updated. Reference Updated	07/21/2020	09/14/2020
Policy was reviewed: 1. Statement about provider sample ‘‘The provision of provider samples does not guarantee coverage…” was added to Clinical Policy. 2. Initial Approval Criteria I.A.5 was updated to include “Request is to be used as a component of repeating the initial successful induction regimen if late relapse (≥12 months since induction regimen) if not administered…”. 3. Initial Approval Criteria I.I.1.b was updated to include “…therapy for primary treatment or treatment of gross residual disease (R2 resection) in abdominal wall tumors if time to response is more critical as a single agent	07/13/2021	09/14/2021

(preferred) for (meets one of the following i, ii, or iii)". 4. Initial Approval Criteria I.I.1.b.i was updated to include "Ongoing progression with potential morbidity or significant symptoms in anatomic location where progression would not be morbid;". 5. Initial Approval Criteria I.I.1.b.ii was updated to include "Documented progression in anatomic location where progression would be morbid;". 6. Initial Approval Criteria I.I.1.b.iii was updated to include "No documented progression in anatomic location where progression would be morbid if concerns for morbidity or significant symptoms;". 7. Continued Therapy Approval Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 8. Appendix A was updated to include abbreviation FLT3-ITD. 9. Therapeutic Alternatives verbiage was rephrased to "Below are suggested therapeutic alternatives based on clinical guidance..". 10. Appendix B: Therapeutic Alternatives was updated to remove inactive/unavailable drug names cabozantinib, sunitinib, and regorafenib. 11. Statement about drug listing format in Appendix B is rephrased to "Therapeutic alternatives are listed as generic (Brand name®) when the drug is available by both generic and brand; Brand name® when the drug is available by brand only and generic name when the drug is available by generic only". 12. References were reviewed and updated.		