

PRIOR AUTHORIZATION POLICY

POLICY: Oncology - Nexavar® (sorafenib tablets – Bayer/Onyx)

TAC APPROVAL DATE: 05/08/2019

OVERVIEW

Nexavar, a kinase inhibitor, is indicated for the treatment of patients with unresectable hepatocellular carcinoma (HCC), treatment of patients with advanced renal cell carcinoma (RCC), and for the treatment of patients with locally recurrent or metastatic, progressive, differentiated thyroid carcinoma (DTC) that is refractory to radioactive iodine treatment.¹ Nexavar decreases tumor cell proliferation *in vitro*, and was shown to inhibit multiple intracellular and cell surface kinases, several of which are thought to be involved in tumor cell signaling, angiogenesis, and apoptosis.

Guidelines

Nexavar features prominently in the National Comprehensive Cancer Network (NCCN) guidelines for hepatobiliary cancer, kidney cancer, thyroid cancer and many uses.

The NCCN clinical practice guidelines on AML (version 3.2019 – May 7, 2019) recommend that for patients who are candidates for less aggressive therapies in relapsed/refractory disease to use low-dose cytarabine intravenous injection or a hypomethylating agent (i.e., 5-azacitidine, decitabine).² For relapse or refractory disease, Nexavar may be added to hypomethylating agents for patients with *FLT3*-ITD (internal tandem duplications of *fms-like tyrosine kinase 3*) mutation-positive disease (category 2A).

The NCCN clinical practice guidelines on thyroid carcinoma (version 1.2019 – March 28, 2019) recommend that in patients with *differentiated thyroid carcinoma* (follicular, papillary, or Hürthle cell), Nexavar be considered for the treatment of progressive and/or symptomatic iodine-refractory unresectable recurrent or persistent locoregional disease or for distant metastatic disease (category 2A).³ The thyroid carcinoma guidelines also recommend that in patients with *medullary thyroid carcinoma*, Nexavar be considered for the treatment of progressive disease or symptomatic distant metastases for one of the following reasons: 1) clinical trials, Caprelsa® (vandetanib tablets), or Cometriq® (cabozantinib capsules) are not available or appropriate, or 2) there is progression on Caprelsa or Cometriq.

The NCCN clinical practice guidelines on hepatobiliary cancer (version 2.2019 – March 6, 2019)⁴ recommend Nexavar as a single agent for patients with hepatocellular carcinoma (adenocarcinoma) [Child Pugh Class A {category 1} or Class B7 {category 2A}]. The NCCN panel recommends Nexavar not be used for adjuvant therapy post-ablation.

The NCCN clinical practice guidelines on kidney cancer (version 4.2019 – April 25, 2019) recommend Nexavar as a single agent for relapse or surgically unresectable Stage IV disease as subsequent therapy for clear cell histology.⁵ It is listed under “useful under certain circumstances” (category 2B).

The NCCN soft tissue sarcoma guidelines (version 2.2019 – February 4, 2019) list single-agent Nexavar as one of the treatment options for patients with angiosarcoma (category 2A) and GIST (after progression on imatinib [Gleevec, generics]), Sutent, and Stivarga. (category 2A).⁶ Nexavar is also recommended for the treatment of desmoid tumors, solitary fibrous tumor, and hemangiopericytoma.

The NCCN bone cancer guidelines (version 2.2019 – April 10, 2019) recommend Nexavar as second-line therapy for relapsed/refractory or metastatic disease and chordoma (both category 2A)⁷

POLICY STATEMENT

Prior authorization is recommended for prescription benefit coverage of Nexavar. All approvals are provided for 3 years.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Nexavar is recommended in those who meet the following criteria:

FDA-Approved Indications

- 1. Renal Cell Carcinoma (RCC).** Approve for 3 years in patients who meet the following criteria (A and B):
 - A) The patient has relapsed or Stage IV clear cell histology RCC; AND
 - B) The patient has tried at least one prior systemic therapy (e.g., Inlyta [axitinib tablets], Votrient [pazopanib tablets], Sutent (sunitinib capsules), Cabometyx (cabozantinib tablets).
- 2. Differentiated (i.e. papillary, follicular, and Hürthle cell) Thyroid Carcinoma.** Approve for 3 years if refractory to radioactive iodine therapy.
- 3. Hepatocellular Carcinoma (HCC), Unresectable.** Approve for 3 years.

Other Uses with Supportive Evidence

- 4. Acute Myeloid Leukemia (AML).** Approve for 3 years if disease is *FLT3*-ITD mutation-positive as detected by an approved test.
- 5. Angiosarcoma.** Approve for 3 years.
- 6. Chordoma.** Approve for 3 years in patients with recurrent disease.
- 7. Desmoid Tumors (aggressive fibromatosis).** Approve for 3 years.
- 8. Gastrointestinal Stromal Tumor (GIST).** Approve for 3 years if the patient meets the following criteria (A, B, and C):
 - A) Patient has previously tried imatinib (Gleevec® tablets, generics); AND
 - B) Patient has previously tried Sutent (sunitinib capsules); AND
 - C) Patient has previously tried Stivarga® (regorafenib tablets).
- 9. Medullary Thyroid Carcinoma.** Approve for 3 years if the patient has tried Caprelsa® (vandetanib tablets) or Cometriq® (cabozantinib capsules).

10. Ovarian, Fallopian Tube, Primary Peritoneal Cancer. Approve for 3 years if the patient meets the following criteria (A and B):

- A) The patient has platinum-resistant disease; AND
- B) Nexavar is used in combination with topotecan.

11. Osteosarcoma. Approve for 3 years if the patient meets the following criteria (A and B):

- A) Patient has tried chemotherapy; AND
- B) Patient has relapsed/refractory or metastatic disease.

12. Solitary Fibrous Tumor and Hemangiopericytoma. Approve for 3 years.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Nexavar has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions. Rationale for non-coverage for these specific conditions is provided below. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval.)

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Nexavar® tablets [prescribing information]. Wayne, NJ: Bayer; December 2017.
2. The NCCN Acute Myeloid Leukemia Clinical Practice Guidelines in Oncology (Version 3.2019 – May 7, 2019). © 2019 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed on May 9, 2019.
3. The NCCN Thyroid Carcinoma Clinical Practice Guidelines in Oncology (Version 1.2019 – March 28, 2019). © 2019 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed on May 9, 2019.
4. The NCCN Hepatobiliary Cancers Clinical Practice Guidelines in Oncology (Version 2.2019 – March 6, 2019). © 2019 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed on May 9, 2019.
5. The NCCN Kidney Cancer Clinical Practice Guidelines in Oncology (Version 4.2019 – April 25, 2019). © 2019 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed on May 9, 2019.
6. The NCCN Soft Tissue Sarcoma Clinical Practice Guidelines in Oncology (Version 2.2019 – February 4, 2019). © 2019 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed on May 9, 2019.
7. The NCCN Bone Cancer Clinical Practice Guidelines in Oncology (Version 2.2019 – April 10, 2019). © 2019 National Comprehensive Cancer Network, Inc. Available at: <http://www.nccn.org>. Accessed on May 9, 2019.

HISTORY

Type of Revision	Summary of Changes*	TAC Approval Date
Annual revision	Renal Cell Carcinoma: Criterion was revised to add that it includes predominant clear cell and non-clear cell histology. Differentiated Thyroid Cancer: Criteria were revised to only require that the patient's disease is refractory to radioactive iodine therapy. Acute Myeloid Leukemia: Criteria were revised to remove all the required conditions of approval. Medullary Thyroid Cancer: Criteria were revised to remove the requirement that the patient has progressive disease or symptomatic distant metastases. Osteosarcoma: Criterion regarding the requirement to try standard chemotherapy was revised to remove the word "standard". Conditions Not Recommended for Approval: Liposarcoma was deleted and the indication, Pancreatic Cancer was changed to Pancreatic Adenocarcinoma.	02/10/2016
Annual revision	Criteria for Chordoma added to Other Uses.	03/08/2017
Annual revision	Solitary Fibrous Tumor and Hemangiopericytoma: New indication was added. Conditions Not Recommended for Approval: Removed Leiomyosarcoma, Lymphoma, and Melanoma.	04/11/2018
Annual revision	<ul style="list-style-type: none"> • Deleted all conditions listed under "Conditions Not Recommended for Approval." • Ovarian, Fallopian Tube, Primary Peritoneal Cancer. Added new approval condition based on compendium/guidelines. • Desmoid Tumors. Deleted "in patients with advanced or unresectable tumors" since it can be used for resectable tumors. • Acute Myeloid Leukemia. Added if "disease is FLT3-ITD mutation-positive based on approved test" according to compendium/guidelines. • Renal Cell Carcinoma (RCC): Deleted "Advanced, (Predominant Clear Cell or Non-Clear Cell Histology)" as condition qualifiers. Added criteria patient has "relapsed or Stage IV clear cell RCC" and patient has tried one prior systemic therapy. No longer used in non-clear cell. 	05/08/2019

TAC – Therapeutic Assessment Committee; * For a summary of criteria changes, refer to respective TAC minutes available at: <http://esidepartments/sites/Dep043/Committees/TAC/Forms/AllItems.aspx>.