PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Sorafenib Prior Authorization Policy
- Nexavar® (sorafenib tablets – Bayer/Onyx, generic)

REVIEW DATE: 06/18/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Sorafenib, a kinase inhibitor, is indicated for the treatment of the following uses:[1]
- **Differentiated thyroid carcinoma**, locally recurrent or metastatic, progressive disease that is refractory to radioactive iodine treatment.
- **Hepatocellular carcinoma** that is unresectable.
- **Renal cell carcinoma** that is advanced.

Guidelines

Sorafenib is discussed in the guidelines from the National Comprehensive Cancer Network (NCCN):[2]
- **Acute Myeloid Leukemia**: NCCN guidelines (version 2.2025 – January 27, 2025) recommend sorafenib + hypomethylating agents (azacitidine or decitabine) for *FLT3*-ITD positive disease for treatment induction or post-induction therapy for patients ≥ 60 years of age and for relapsed/refractory disease (category 2A).[3] Single-agent sorafenib is recommended as

maintenance therapy for patients who are post-allogeneic stem cell transplantation, in remission, and have a *FLT3*-ITD mutation (category 2A).

- **Bone Cancer**: NCCN guidelines (version 2.2025 – February 28, 2025) recommend sorafenib as a systemic therapy agent, "useful in certain circumstances", for recurrent chordoma (category 2A).[4] It also recommends sorafenib for osteosarcoma as a second-line therapy for relapsed/refractory or metastatic disease as a "preferred regimen" (category 2A) and as "other recommended regimens" in combination with everolimus (category 2B).
- **Gastrointestinal Stromal Tumor**: NCCN guidelines (version 1.2025 – April 17, 2025) recommend sorafenib (category 2A) as an additional option, "useful in certain circumstances", after failure on approved therapies.[5] The first-line preferred therapy is imatinib; second-line therapy is sunitinib; third-line therapy is Stivarga® (regorafenib tablets); fourth-line therapy is Qinlock® (ripretinib tablets).
- **Hepatocellular Carcinoma**: NCCN guidelines (version 1.2025 – March 20, 2025) recommend sorafenib as a first-line systemic therapy option as "Other Recommended Regimens" (category 1for unresectable, inoperable, or metastatic hepatocellular carcinoma.[6]
- **Kidney Cancer**: NCCN guidelines (version 3.2025 – January 9, 2025) no longer recommend sorafenib as a treatment option for kidney cancer.[7] Approval condition left in policy due to FDA approved indication.
- **Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions**: NCCN guidelines (version 2.2025 – April 4, 2025) recommend sorafenib for myeloid/lymphoid neoplasms with *FLT3* rearrangements (category 2A).[8]
- **Ovarian Cancer Including Fallopian Tube Cancer and Primary Peritoneal Cancer**: NCCN guidelines (version 2.2025 – May 23, 2025) recommend sorafenib + topotecan (category 2A) as "Other Recommended Regimen" option as recurrence therapy for platinum-resistant disease.[9]
- **Soft Tissue Sarcoma**: NCCN guidelines (version 1.2025 – May 2, 2025) recommend sorafenib as single-agent therapy under "Useful in Certain Circumstances" for angiosarcoma (category 2A); sorafenib as a "Preferred" single-agent regimen for desmoid tumors (aggressive fibromatosis) (category 1) and for solitary fibrous tumor (category 2A).[10]
- **Thyroid Carcinoma**: NCCN guidelines (version 1.2025 – March 27, 2025) for differentiated thyroid carcinoma recommend sorafenib as "other recommended regimens" for progressive and/or symptomatic disease for locally recurrent, advanced, and/or metastatic disease not amenable to radioactive iodine therapy (category 1).[11] The guidelines note that a majority of oncocytic carcinoma are non-iodine-avid, so "radioactive-iodine refractory" may not be applicable to oncocytic carcinoma. Sorafenib can be considered for treatment of progressive or symptomatic medullary thyroid disease if clinical trials or preferred systemic therapy options are not available or appropriate, or if there is progression on preferred systemic therapy options.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of sorafenib. All approvals are provided for the duration noted below.

- **Nexavar® (sorafenib tablets - Bayer/Onyx, generic)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indications

1. **Hepatocellular Cancer.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has unresectable or metastatic disease.

2. **Renal Cell Cancer.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has relapsed or advanced disease; AND
   C) Patient has clear cell histology AND
   D) Patient has tried at least one systemic therapy.
   Note: Examples of systemic therapy include Inlyta (axitinib tablets), pazopanib, sunitinib, Cabometyx (cabozantinib tablets).

3. **Thyroid Carcinoma, Differentiated.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   Note: Examples of differentiated thyroid carcinoma include papillary, follicular, and oncocytic carcinoma (formerly Hürthle cell carcinoma).
   A) Patient is ≥ 18 years of age; AND
   B) Patient meets ONE of the following (i or ii):
      i. Patient meets BOTH of the following (a and b):
         a) Patient has papillary or follicular thyroid carcinoma; AND
         b) The disease is refractory to radioactive iodine therapy; OR
      ii. Patient has oncocytic (formerly Hürthle cell) carcinoma.

Other Uses with Supportive Evidence

4. **Acute Myeloid Leukemia.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has *FLT3*-ITD mutation-positive disease as detected by an approved test; AND
   C) Patient meets ONE of the following (i or ii):
      i. This medication is used in combination with azacitidine or decitabine; OR
      ii. Patient has had an allogeneic stem cell transplant and is in remission.

5. **Bone Cancer.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) Patient meets ONE of the following (i or ii):
      i. Patient has recurrent chordoma; OR
      ii. Patient meets BOTH of the following (a and b):
         a) Patient has osteosarcoma; AND
         b) Patient has tried one systemic chemotherapy regimen.
         Note: Examples of a systemic chemotherapy regimen contain one of more of the following products: cisplatin, doxorubicin, methotrexate, or ifosfamide.

6. **Gastrointestinal Stromal Tumor.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has previously tried ALL of the following (i, ii, iii, and iv):
      i. imatinib; AND
      ii. sunitinib; AND
      iii. Stivarga (regorafenib tablets); AND
      iv. Qinlock (ripretinib tablets).

7. **Myeloid/Lymphoid Neoplasms with Eosinophilia.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) The tumor has an *FLT3* rearrangement.

8. **Ovarian, Fallopian Tube, Primary Peritoneal Cancer**. Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has platinum-resistant disease; AND
   C) Sorafenib is used in combination with topotecan.

9. **Soft Tissue Sarcoma.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has ONE of the following diagnoses (i, ii, or iii):
      i. Angiosarcoma; OR

ii. Desmoid tumors (aggressive fibromatosis); OR
iii. Solitary Fibrous Tumor/Hemangiopericytoma.

10. Thyroid Carcinoma, Medullary. Approve for 1 year if the patient meets BOTH of the following (A and B):
A) Patient is ≥ 18 years of age; AND
B) Patient has tried at least one systemic therapy.
Note: Examples of systemic therapy include: Caprelsa (vandetanib tablets), Cometriq (cabozantinib capsules), Retevmo (selpercatinib capsules), and Gavreto (pralsetinib capsules).

CONDITIONS NOT COVERED

- **Nexavar® (sorafenib tablets - Bayer/Onyx, generic)**

is(are) considered not medically necessary for ANY other use(s); criteria will be updated as new published data are available.

REFERENCES

1. Sorafenib® tablets [prescribing information]. Wayne, NJ: Bayer; August 2023.
2. The NCCN Drugs and Biologics Compendium. © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed June 12, 2025. Search term: sorafenib
3. The NCCN Acute Myeloid Leukemia Clinical Practice Guidelines in Oncology (version 2.2025 – January 27, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed June 12, 2025.
4. The NCCN Bone Cancer Clinical Practice Guidelines in Oncology (version 2.2025 – February 28, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed June 12, 2025.
5. The NCCN Gastrointestinal Stromal Tumor (GIST) Clinical Practice Guidelines in Oncology (version 1.2025 – April 17, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed June 12, 2025.
6. The NCCN Hepatocellular Carcinoma Clinical Practice Guidelines in Oncology (version 1.2025 – March 20, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed June 12, 2025.
7. The NCCN Kidney Cancer Clinical Practice Guidelines in Oncology (version 3.2025 – January 9, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed June 12, 2025.
8. The NCCN Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Gene Fusions Clinical Practice Guidelines in Oncology (version 2.2025 – April 4, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed June 12, 2025.
9. The NCCN Ovarian Cancer Including Fallopian Tube Cancer and Primary Peritoneal Cancer Clinical Practice Guidelines in Oncology (version 2.2025 – May 23, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed June 12, 2025.
10. The NCCN Soft Tissue Sarcoma Clinical Practice Guidelines in Oncology (version 1.2025 – May 2, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed June 12, 2025.
11. The NCCN Thyroid Carcinoma Clinical Practice Guidelines in Oncology (version 1.2025 – March 27, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed June 12, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	Throughout the policy changed Nexavar to sorafenib due to generic availability.	06/07/2023

	Thyroid Carcinoma, Differentiated: For examples of thyroid carcinoma, changed Hürthle cell carcinoma name to "oncocytic carcinoma (formerly Hürthle cell carcinoma)" based on guideline changes.	
Annual Revision	No criteria changes.	06/19/2024
Annual Revision	**Thyroid Carcinoma, Differentiated:** Moved Note listing the different types of differentiate thyroid carcinoma to be under the indication. Separated criteria such that radioactive iodine-refractory disease is applicable to only follicular or papillary carcinoma and not for oncocytic carcinoma. **Gastrointestinal Stromal Tumor:** Deleted Ayvakit and Sprycel as therapy options from criteria.	06/18/2025