PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Oncology – Sorafenib Preferred Specialty Management Policy
- Nexavar® (sorafenib tablets – Bayer/Onyx, generic)

REVIEW DATE: 07/13/2022

OVERVIEW

Sorafenib, a kinase inhibitor, is indicated for the treatment of the following:[1-2]

- **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.

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of the Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the standard *Oncology – Sorafenib Prior Authorization Policy* criteria. The program also directs the patient to try the Preferred Product prior to the approval of a Non-Preferred Product. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). If the patient meets the standard *Oncology – Sorafenib Prior Authorization Policy* criteria but has not tried a Preferred Product, approval for a Preferred Product will be authorized. All approvals are provided for 1 year.

Documentation: Documentation is required for use of Nexavar as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and/or other information.

Automation: None.

Preferred Products: generic sorafenib tablets
Non-Preferred Products: Nexavar

RECOMMENDED EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Nexavar	**1.** Approve for 1 year if the patient meets ALL of the following (A, B, and C): **A)** Patient meets the standard *Oncology – Sorafenib Prior Authorization Policy* criteria; AND **B)** Patient has tried generic sorafenib tablets **[documentation required]**; AND **C)** Patient cannot continue to use the Preferred medication due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] which, per the prescriber, would result in a significant allergy or serious adverse reaction **[documentation required]**. **2.** If the patient has met the standard *Oncology – Sorafenib Prior Authorization Policy* criteria (1A), but has not met exception criteria (1B) and/or (1C) above for brand Nexavar: approve generic sorafenib tablets.

REFERENCES

1. Nexavar® tablets [prescribing information]. Wayne, NJ: Bayer; July 2020.
2. Sorafenib tablets [prescribing information]. Princeton, NJ: Dr. Reddy's; April 2022.