

The following policy is for medication that falls under the Medicare Part D benefit only.

**Prior Authorization Group:** NEXAVAR Policy

**Drug(s):** NEXAVAR (sorafenib)

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D. All criteria in "other criteria" section must be met for coverage.

**Required Medical Information:** Radiologic reports. Medical history.

**Age Restrictions:** Restricted to 18 years of age or older.

**Prescriber Restrictions:** Prescribed by oncologist or hematologist.

**Other Criteria:**

Criteria and use of this agent must follow the FDA package label and the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology.

Extension of therapy is dependent upon radiologic or hematologic and cytogenic documentation of absence of disease progression and continued benefit from therapy.

**Exclusion Criteria:** Coverage for Nexavar will not be provided if any of the following situations are true: doses exceeding package labeling, more than 4 tablets daily, use in cancer other than advanced renal cell carcinoma or inoperable liver cancer, documented progression while receiving therapy.

**Coverage Duration:** 3 months initial approval. 6 months for extension of therapy.