Reference number(s)
1809-A

Specialty Guideline Management
Stivarga

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Stivarga	regorafenib

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-approved Indications[1]

Colorectal cancer

Stivarga is indicated for the treatment of patients with metastatic colorectal cancer (CRC) who have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-vascular endothelial growth factor (VEGF) therapy, and, if RAS wild type, an anti-epidermal growth factor receptor (EGFR) therapy.

Gastrointestinal stromal tumors

Stivarga is indicated for the treatment of patients with locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) who have been previously treated with imatinib mesylate and sunitinib malate.

Hepatocellular carcinoma

Stivarga is indicated for the treatment of patients with hepatocellular carcinoma (HCC) who have been previously treated with sorafenib.

Compendial Uses[2]

- Advanced or metastatic colorectal cancer
- Gastrointestinal stromal tumors (GIST)
- Soft tissue sarcoma
    - Non-adipocytic sarcoma (including extremity/body wall, head/neck and retroperitoneal/intra-abdominal soft tissue sarcomas)
    - Rhabdomyosarcoma
    - Angiosarcoma
- Hepatocellular carcinoma
- Osteosarcoma
- Central nervous system (CNS) cancers:
    - Glioblastoma
    - High-grade glioma
- Ewing sarcoma
- Uterine sarcoma

All other indications are considered experimental/investigational and not medically necessary.

Coverage Criteria

Colorectal Cancer (CRC)[1-4]

Authorization of 12 months may be granted for treatment of advanced or metastatic colorectal cancer, including appendiceal adenocarcinoma and anal adenocarcinoma, as a single agent when the member has progressed on previous treatment with all the following regimens unless the member has a contraindication or intolerance:

- Fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy (with or without bevacizumab); and
- If RAS mutation status is negative (wild-type), an anti-epidermal growth factor receptor (EGFR) therapy, such as Erbitux (cetuximab) or Vectibix (panitumumab), for rectal cancer, appendiceal adenocarcinoma, anal adenocarcinoma, or left-sided colon cancer.

Gastrointestinal Stromal Tumor (GIST)[1,2]

Authorization of 12 months may be granted for treatment of GIST when any of the following criteria are met:

- The requested medication will be used as a single agent for locally advanced, residual, unresectable, tumor rupture, or recurrent/metastatic GIST following disease progression on imatinib and either sunitinib or ripretinib
- The requested medication will be used for treatment of residual, unresectable, tumor rupture or recurrent/metastatic GIST in combination with everolimus for disease progression after the member has failed at least four FDA-approved therapies (e.g., imatinib, sunitinib, ripretinib, avapritinib)
- The requested medication will be used for treatment of residual, unresectable, tumor rupture or recurrent/metastatic succinate dehydrogenase (SDH)-deficient GIST as a single agent.

Hepatocellular carcinoma[1,2]

Authorization of 12 months may be granted for subsequent treatment of unresectable or extrahepatic/metastatic hepatocellular carcinoma, as a single agent.

Soft tissue sarcomas[2]

Authorization of 12 months may be granted for treatment of angiosarcoma, rhabdomyosarcoma, and non-adipocytic sarcoma (including extremity/body wall, head/neck and retroperitoneal/intra-abdominal soft tissue sarcomas), as a single agent.

Osteosarcoma[2]

Authorization of 12 months may be granted for subsequent treatment of relapsed/refractory or metastatic osteosarcoma as a single agent.

Central nervous system (CNS) cancers[2]

Authorization of 12 months may be granted for treatment of recurrent or progressive glioblastoma or high-grade glioma, as a single agent.

Ewing sarcoma[2]

Authorization of 12 months may be granted for subsequent treatment of relapsed (with or without radiation), progressive or metastatic Ewing sarcoma as a single agent.

Uterine sarcoma[2]

Authorization of 12 months may be granted for subsequent treatment of advanced, recurrent/metastatic, or inoperable uterine sarcoma as a single agent.

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Continuation of Therapy

Gastrointestinal Stromal Tumor (GIST)

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for treatment of GIST when there is no evidence of unacceptable toxicity while on the current regimen.

All Other Indications

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for all other indications listed in the coverage criteria section when there is no evidence of unacceptable toxicity or disease progression while on the current regimen.

References

1. Stivarga [package insert]. Whippany, NJ: Bayer HealthCare Pharmaceuticals Inc.; December 2020.
2. The NCCN Drugs & Biologics Compendium 2025 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org. Accessed January 16, 2025.
3. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines): Anal Carcinoma. Version 1.2024. Accessed July 8, 2024. https://www.nccn.org/professionals/physician_gls/pdf/anal.pdf
4. NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines): Colon Cancer. Version 4.2024. Accessed July 8, 2024. https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf