PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Oncology – BRAF and MEK Inhibitors Preferred Specialty Management Policy

BRAF/MEK Pairing	Inhibitor	Mechanism of Action	Manufacturer
• Braftovi™ capsules) • Mektovi® tablets)	(encorafenib (binimetinib	BRAF Inhibitor MEK Inhibitor	Array BioPharma
• Tafinlar® capsules) • Mekinist® tablets)	(dabrafenib (trametinib	BRAF Inhibitor MEK Inhibitor	Novartis
• Zelboraf® tablets) • Cotellic® tablets)	(vemurafenib (cobimetinib	BRAF Inhibitor MEK Inhibitor	Genentech/Roche

REVIEW DATE: 10/11/2023; selected revision 10/18/2023, policy effective 01/01/2024

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. 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

All three of the BRAF/MEK inhibitor combinations are FDA-approved for the treatment of melanoma with *BRAF V600* mutation: Braftovi + Mektovi, Tafinlar + Mekinist, and Zelboraf + Cotellic.[1-6] In addition, these agents also have other FDA-approved indications.

GUIDELINES

Metastatic or Unresectable Melanoma

The National Comprehensive Cancer Network (NCCN) guidelines for cutaneous melanoma (version 2.2023 – March 10, 2023) recommend BRAF/MEK inhibitor combinations for treatment of metastatic or unresectable melanoma with a *BRAF V600*-activating mutation under "other Non-Preferred Product regimens" (category 1 for all combinations) for first-line therapy.[8] All three combinations are listed under "preferred regimens" (all category 2A) for second-line or subsequent therapy. While combination BRAF/MEK inhibition is preferred, if a combination is contraindicated, monotherapy with a BRAF inhibitor is a Non-Preferred Product option.

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of a Preferred Product prior to a Non-Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the respective standard *Prior Authorization Policy* criteria and to try one of the Preferred Products prior to the approval of a Non-Preferred Product. Requests for the Non-Preferred Product will be reviewed using the exception criteria (below). If the patient meets the standard Prior Authorization Policy criteria for the Non-Preferred Product, but has not tried one of the Preferred Products, a review will be offered for the Preferred Products using the respective standard *Prior Authorization Policy* criteria. All approvals are provided for the duration noted below.

BRAF Inhibitor Preferred Products: Zelboraf, Tafinlar
BRAF Inhibitor Non-Preferred Product: Braftovi

MEK Inhibitor Preferred Products: Cotellic, Mekinist
MEK Inhibitor Non-Preferred Product: Mektovi

Oncology – BRAF and MEK Inhibitors non-preferred product(s) is(are) covered as medically necessary when the following non-preferred product exception criteria is(are) met. Any other exception is considered not medically necessary.

NON-PREFERRED PRODUCT EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Braftovi	**1. Melanoma, *BRAF V600* Mutation-Positive Disease:** Approve for 1 year if the patient meets the following (A or B): **A)** Patient meets the following (i and ii): **i.** Patient meets the standard *Oncology – Braftovi Prior Authorization (PA) Policy* criteria; AND **ii.** Patient meets one of the following (a or b): **a)** Patient has tried one of Zelboraf or Tafinlar; OR **b)** Patient is currently receiving Braftovi; OR **B)** If the patient has met the standard *Oncology – Braftovi PA Policy* criteria, but has not met the exception criteria above (**Aii**), offer to review for one of the Preferred Products using either the standard *Oncology – Zelboraf PA Policy* criteria **or** the *Oncology – Tafinlar PA Policy* criteria. **2. Other Conditions:** Approve for 1 year if the patient meets the standard *Oncology – Braftovi PA Policy* criteria.
Mektovi	**1. Melanoma, *BRAF V600* Mutation-Positive Disease:** Approve for 1 year if the patient meets the following (A or B): **A)** Patient meets the following (i and ii): **i.** Patient meets the standard *Oncology – Mektovi Prior Authorization (PA) Policy* criteria; AND **ii.** Patient meets one of the following (a or b): **a)** Patient has tried one of Cotellic or Mekinist; OR **b)** Patient is currently receiving Mektovi; OR **B)** If the patient has met the standard Oncology – Mektovi PA Policy criteria, but has not met the exception criteria above (**Aii**), offer to review for one of the Preferred Products using either the standard *Oncology – Cotellic PA Policy* criteria **or** the *Oncology – Mekinist PA Policy* criteria. **2. Other Conditions**: Approve for 1 year if the patient meets the standard *Oncology – Mektovi PA Policy* criteria.

REFERENCES

1. Cotellic™ tablets [prescribing information]. South San Francisco, CA: Genentech/Roche; May 2023.
2. Mekinist® tablets [prescribing information]. East Hanover, NJ: Novartis; August 2023.
3. Tafinlar® capsules [prescribing information]. East Hanover, NJ: Novartis; August 2023.
4. Zelboraf® tablets [prescribing information]. South San Francisco, CA: Genentech; May 2020.
5. Mektovi® tablets [prescribing information]. Boulder, CO: Array BioPharma; October 2023.
6. Braftovi™ capsules [prescribing information]. Boulder, CO: Array BioPharma; October 2023.
7. The NCCN Melanoma Clinical Practice Guidelines in Oncology (version 2.2023 – March 10, 2023). © 2023 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on October 6, 2023.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	Effective 01/01/2024	10/11/2023
Selected Revision	Policy Effective: 01/01/2024. For Braftovi and Mektovi exception criteria to be consistent, deleted the verbiage "…experienced inadequate efficacy, significant intolerance, or other exceptional clinical circumstance".	10/18/2023