LifeWise
Health Plan of Washington

PHARMACY POLICY – 5.01.589
BRAF and MEK Inhibitors

Effective Date:	May 1, 2025	RELATED MEDICAL POLICIES:	
Last Revised:	Apr. 8, 2025	5.01.543	General Medical Necessity Criteria for Companion Diagnostics Related to Drug Approval
Replaces:	N/A		

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

BRAF and MEK are proteins involved in a key pathway that sends signals inside cells which stimulate cell growth. It is faulty (mutated) in some human cancers. The defective proteins signal constantly, stimulating overgrowth of the cells. BRAF and MEK inhibitors stop this signaling. This has been shown to slow the growth of melanomas that have spread through the body and can't be removed by surgery. This policy describes when BRAF and MEK inhibitors may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Drug	Medical Necessity
BRAF/MEK Inhibitors	
Combination therapy for melanoma: **Braftovi + Mektovi** **Tafinlar + Mekinist** **Zelboraf + Cotellic**	**The following combination regimens may be considered medically necessary for treatment of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation:** • Braftovi (encorafenib) and Mektovi (binimetinib) • Tafinlar (dabrafenib) and Mekinist (trametinib) • Zelboraf (vemurafenib) and Cotellic (cobimetinib) **Note**: Testing for BRAF V600 mutations is covered whenever use of BRAF inhibitors is contemplated.
Combination therapy for metastatic colorectal cancer: **Braftovi + Erbitux**	**The following combination regimens may be considered medically necessary for the treatment of metastatic colorectal cancer with a BRAF V600E mutation in individuals aged 18 years or older:** • Braftovi (encorafenib) and Erbitux (cetuximab), after prior therapy • Braftovi (encorafenib) in combination with Erbitux (cetuximab) and mFOLFOX6 (fluorouracil, leucovorin, and oxaliplatin) **Note**: Testing for BRAF V600 mutations is covered whenever use of BRAF inhibitors is contemplated.
Combination therapy for metastatic non-small cell lung cancer (NSCLC): **Braftovi + Mektovi**	**The following combination regimen may be considered medically necessary for the treatment of metastatic non-small cell lung cancer (NSCLC) with a BRAF V600E mutation in individuals aged 18 years or older:** • Braftovi (encorafenib) and Mektovi (binimetinib) **Note**: Testing for BRAF V600 mutations is covered whenever use of BRAF inhibitors is contemplated.
Combination therapy for other indications: **Tafinlar + Mekinist**	**Tafinlar (dabrafenib) in combination with Mekinist (trametinib) may be considered medically necessary for:** • Adjuvant treatment of individuals with melanoma with BRAF V600E or V600K mutations and involvement of lymph node(s), following complete resection • Treatment of individuals with metastatic non-small cell lung cancer with BRAF V600E mutations

Drug	Medical Necessity
BRAF/MEK Inhibitors	
	• Treatment of individuals with locally advanced or metastatic anaplastic thyroid cancer with BRAF V600E mutation and with no satisfactory locoregional treatment options • Treatment of adult and pediatric individuals aged 1 year and older with unresectable or metastatic solid tumors with BRAF V600E mutation who have progressed following prior treatment and have no satisfactory alternative treatment options • Treatment of pediatric individuals aged 1 year to 17 years with low grade glioma with BRAF V600E mutation who require systemic therapy **Note**: Testing for BRAF V600 mutations is covered whenever use of BRAF inhibitors is contemplated.
Monotherapy with Cotellic (cobimetinib)	**Cotellic (cobimetinib), as a single agent, may be considered medically necessary for the treatment of histiocytic neoplasms in individuals aged 18 years or older.**
Monotherapy with Tafinlar (dabrafenib)	**Tafinlar (dabrafenib) monotherapy may be considered medically necessary for:** • Treatment of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation. **Note**: Testing for BRAF V600 mutations is covered whenever use of BRAF inhibitors is contemplated.
Monotherapy with Zelboraf (vemurafenib)	**Zelboraf (vemurafenib) monotherapy may be considered medically necessary for:** • Treatment of unresectable or metastatic melanoma with a BRAF V600E mutation **OR** • Treatment of individuals with Erdheim-Chester Disease with BRAF V600 mutation **Note**: Testing for BRAF V600 mutations is covered whenever use of BRAF inhibitors is contemplated.

Drug	Medical Necessity
BRAF/MEK Inhibitors	
Monotherapy with Mekinist (trametinib)	**Mekinist (trametinib) monotherapy may be considered medically necessary for the treatment of BRAF-inhibitor treatment-naïve individuals with unresectable or metastatic melanoma with BRAF V600E or V600K mutations** **Note**: Testing for BRAF V600 mutations is covered whenever use of BRAF inhibitors is contemplated.
Gomekli (mirdametinib)	**Gomekli (mirdametinib) may be considered medically necessary for the treatment of neurofibromatosis type 1 (NF1) when the following are met:** • The individual is aged 2 years or older **AND** • Diagnosed with neurofibromatosis type 1 who have symptomatic, inoperable plexiform neurofibromas **AND** • For individuals aged 2 to 17 years, they have tried and had an inadequate response or intolerance to Koselugo (selumetinib) or documentation is provided that the individual is unable to swallow the Koselugo capsules **AND** • Gomekli (mirdametinib) is prescribed by, or in consultation with, an oncologist or neurologist **AND** • The prescribed dose is less than or equal to 4 mg twice daily
Koselugo (selumetinib)	**Koselugo (selumetinib) may be considered medically necessary for the treatment of pediatric individuals aged 2 years to 17 years with neurofibromatosis type 1 who have symptomatic, inoperable plexiform neurofibromas.**
Ojemda (tovorafenib)	**Ojemda (tovorafenib) may be considered medically necessary for the treatment of pediatric individuals aged 6 months to 17 years with relapsed or refractory pediatric low-grade glioma (LGG) harboring a BRAF fusion or rearrangement, or BRAF V600 mutation.**

Drug	Not Medically Necessary
As listed	**Use of BRAF and/or MEK inhibitors for treatment of individuals with wild-type BRAF is considered not medically necessary.**

Drug	Investigational
As listed	**All other uses of the medications listed in this policy are considered investigational.** **The drugs listed in this policy are subject to the product's US Food and Drug Administration (FDA) dosage and administration prescribing information.**

Length of Approval	
Approval	**Criteria**
Initial authorization	**Non-formulary exception reviews for all drugs listed in the policy may be approved up to 12 months.** **All other reviews for all drugs listed in policy may be approved up to 3 months.**
Re-authorization criteria	**Non-formulary exception reviews and all other reviews for drugs listed in policy may be approved up to 12 months as long as the drug-specific coverage criteria are met, and chart notes demonstrate that the individual continues to show a positive clinical response to therapy.**

Documentation Requirements
The individual's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following: • Chart notes demonstrating that the individual meets the stated criteria for medical necessity • For BRAF inhibitors, test results showing the presence of BRAF V600 mutations must be included

Coding

N/A

Related Information

Benefit Application

The drugs in this policy are managed through the pharmacy benefit.

Evidence Review

Melanoma

Melanoma accounts for only about 1% of skin cancers but, because it is more likely to metastasize than squamous cell or basal cell cancers, it causes a large amount of skin cancer deaths. If recognized and treated early, it is almost always curable. Approximately 84% of melanomas are diagnosed at a localized stage with 5-year survival of 98%. However, the 5-year survival for the 4% of individuals with metastatic disease at diagnosis is 15%.

The American Cancer Society estimates that approximately 104,960 new melanomas will be diagnosed (approximately 60,550 in men and 44,410 in women), and that approximately 8,430 people will die of melanoma (approximately 5,470 men and 2,960 women) in 2025 in the U.S.

Overall, the lifetime risk of getting melanoma is about 3% (1 in 33) for White people, 0.1% (1 in 1,000) for Black people, and 0.5% (1 in 200) for Hispanic people. Major risk factors for melanoma include atypical nevi (moles), more than 50 benign or atypical nevi, giant congenital nevus, and a personal or family history of melanoma. Other risk factors for all skin cancer types include: sun sensitivity (defined as easily being sunburned), freckling, tanning with difficulty, or having naturally blond or red hair. Other risk factors include having a history of excessive sun exposure (including sunburns), use of tanning booths and immune-deficiency states (e.g., immunosuppressive chemotherapy, post-transplant immunosuppression, human immunodeficiency virus/ acquired immunodeficiency syndrome).

$BRAF^{V600E}$ Mutation and Response to Dabrafenib, Encorafenib and Vemurafenib (BRAF Inhibitors) and Binimetinib, Cobimetinib and Trametinib (MEK Inhibitors)

BRAF (B member of the Rapidly Accelerated Fibrosarcoma family of serine/threonine tyrosine kinases) is a protein that in normal melanocytes is part of the mitogen-activated protein kinase (MAPK) – extracellular signal-regulated kinase (ERK) signal transduction pathway. This signaling pathway controls cell growth, survival, differentiation and senescence. More than 40 mutations of BRAF are known in human cancer, 90% to 95% of which are V600E, in which glutamic acid is substituted for valine at amino acid position 600. Mutated BRAF leads to constitutive activation of the MAPK-ERK signaling pathway, resulting in tumor maintenance and progression. BRAF mutation may be a negative prognostic indicator in metastatic melanoma.

Summary of Evidence

Encorafenib/Binimetinib

Encorafenib in combination with binimetinib was evaluated in a randomized, active-controlled, open-label, multicenter trial (COLUMBUS; NCT01909453). Eligible individuals were required to have BRAF V600E or V600K mutation-positive unresectable or metastatic melanoma. Individuals could have received immunotherapy for unresectable locally advanced or metastatic disease. Prior use of BRAF inhibitors or MEK inhibitors was prohibited. Individuals were randomized (1:1:1) to receive encorafenib 450 mg once daily in combination with binimetinib 45 mg twice daily (encorafenib in combination with binimetinib), encorafenib 300 mg once daily, or vemurafenib 960 mg twice daily. Treatment continued until disease progression or unacceptable toxicity.

A total of 577 individuals were randomized, 192 to the encorafenib in combination with binimetinib arm, 194 to the encorafenib arm, and 191 to the vemurafenib arm. Of the 383 individuals randomized to either the encorafenib in combination with binimetinib or the vemurafenib arms, the median age was 56 years (20 to 89 years), 59% were male, 91% were White, and 72% had baseline Eastern Cooperative Oncology Group (ECOG) performance status of 0. Of these 95% had metastatic disease, 65% were Stage IVM1c, and 4% received prior immunotherapy. Twenty-eight percent (28%) had elevated baseline serum lactate dehydrogenase (LDH), 45% had ≥ 3 organs with tumor involvement at baseline, and 3% had

brain metastases. Based on centralized testing, 100% of individuals' tumors tested positive for BRAF mutations; BRAF V600E (88%), BRAF V600K (11%), or both (<1%). Encorafenib in combination with binimetinib demonstrated a statistically significant improvement in median progression-free survival (PFS) (14.9 months compared to 7.3 months with vemurafenib monotherapy.

Dabrafenib/Trametinib

The safety and efficacy of dabrafenib co-administered with trametinib were evaluated in two international, randomized, active-controlled trials: one double-blind trial (the COMBI-d study; NCT01584648) and one open-label trial (the COMBI-v study; NCT01597908). The COMBI-d study compared dabrafenib and trametinib to dabrafenib and placebo as first-line therapy for individuals with unresectable (Stage IIIC) or metastatic (Stage IV) BRAF V600E or V600K mutation-positive cutaneous melanoma. Individuals were randomized (1:1) to receive dabrafenib 150 mg twice daily and trametinib 2 mg once daily or dabrafenib 150 mg twice daily plus matching placebo. Randomization was stratified by LDH level (> the upper limit of normal (ULN) vs. ≤ ULN) and BRAF mutation subtype (V600E vs. V600K). The major efficacy outcome was investigator-assessed PFS per RECIST v1.1 with additional efficacy outcome measures of overall survival (OS) and confirmed overall response rate (ORR).

The COMBI-v study compared dabrafenib and trametinib to vemurafenib as first-line treatment therapy for individuals with unresectable (Stage IIIC) or metastatic (Stage IV) BRAF V600E or V600K mutation-positive cutaneous melanoma. Individuals were randomized (1:1) to receive dabrafenib 150 mg twice daily and trametinib 2 mg once daily or vemurafenib 960 mg twice daily. Randomization was stratified by LDH level (> the ULN vs. ≤ ULN) and BRAF mutation subtype (V600E vs. V600K). The major efficacy outcome measure was overall survival. Additional efficacy outcome measures were PFS and ORR as assessed by investigator per RECIST v1.1.

In the COMBI-d study, 423 individuals were randomized to dabrafenib plus trametinib (n = 211) or dabrafenib plus placebo (n = 212). The median age was 56 years (range: 22 to 89 years), 53% were male, > 99% were White, 72% had ECOG performance status of 0, 4% had Stage IIIC, 66% had M1c disease, 65% had a normal LDH, and 2 individuals had a history of brain metastases. All individuals had tumor containing BRAF V600E or V600K mutations as determined by centralized testing, 85% with BRAF V600E mutations and 15% with BRAF V600K mutations.

In the COMBI-v study, 704 individuals were randomized to dabrafenib plus trametinib (n = 352) or single-agent vemurafenib (n = 352). The median age was 55 years (range: 18 to 91 years), 96% were White, and 55% were male, 6% percent of individuals had Stage IIIC, 61% had M1c

disease, 67% had a normal LDH, 70% had ECOG performance status of 0, 89% had BRAF V600E mutation-positive melanoma, and one individual had a history of brain metastases.

The COMBI-d and COMBI-v studies demonstrated statistically significant improvements in PFS: 11.4 months with dabrafenib+trametinib (95% CI 9.9, 14.9) vs 7.3 months (5.8, 7.8) with vemurafenib.

A phase 2/3 randomized, open-label, global, parallel assignment study was conducted to evaluate the safety and efficacy of dabrafenib in combination with trametinib in individuals with BRAFV600 mutation positive low-grade glioma (LGG) or relapsed/refractory high-grade glioma (HGG). Individuals were randomized to receive either dabrafenib in combination with trametinib or carboplatin in combination with vincristine. The primary efficacy endpoint was ORR in the first 32 weeks of treatment, and the individuals in the treatment group had a statistically significant ORR of 47% compared to 11% for the chemotherapy group ($p < 0.001$). The secondary efficacy endpoints were duration of response, progression-free survival, and overall survival. The result showed that the individuals in the treatment group had a median progression-free survival (PFS) of 20.1 months, which was significantly longer than the 7.4 months observed in the chemotherapy group ($p < 0.001$). Furthermore, 89% of individuals in the treatment group experienced a reduction in tumor size compared to baseline, while only 70% of the individuals in the chemotherapy group had a reduction in the tumor size compared to the baseline.

Pyrexia, vomiting, and headache were among the common adverse events observed in the treatment group. About 47% individuals in the treatment group had grade 3 or higher adverse events, which was significantly lower than the 94% observed in the chemotherapy group. The discontinuation rate due to adverse events was also lower in the treatment group, with only 4% individuals discontinuing the treatment, compared to 18% in the chemotherapy group.

Vemurafenib/Cobimetinib

The safety and efficacy of vemurafenib+cobimetinib was established in a multicenter, randomized (1:1), double-blinded, placebo-controlled trial conducted in 495 individuals with previously untreated, BRAF V600 mutation-positive, unresectable or metastatic, melanoma. All individuals received vemurafenib 960 mg orally twice daily on days 1–28 and were randomized to receive cobimetinib 60 mg or matching placebo orally once daily on days 1–21 of an every 28-day cycle. Randomization was stratified by geographic region (North America vs. Europe vs. Australia/New Zealand/others) and disease stage (unresectable Stage IIIc, M1a, or M1b vs. Stage M1c). Treatment continued until disease progression or unacceptable toxicity. Individuals randomized to receive placebo were not offered cobimetinib at the time of disease progression.

The major efficacy outcome was investigator-assessed progression-free survival (PFS) per RECIST v1.1. The median age of the study population was 55 years (range 23 to 88 years), 58% of individuals were male, 93% were White and 5% had no race reported, 60% had stage M1c disease, 72% had a baseline ECOG performance status of 0, 45% had an elevated baseline serum LDH, 10% had received prior adjuvant therapy, and <1% had previously treated brain metastases. Individuals with available tumor samples were retrospectively tested using next generation sequencing to further classify mutations as V600E or V600K; test results were obtained on 81% of randomized individuals. Of these, 86% were identified as having a V600E mutation and 14% as having a V600K mutation. Median PFS was 12.3 months (95% CI 9.5, 13.4) vs. 7.2 months with vemurafenib monotherapy (5.6,7.5).

Tovorafenib

The efficacy of tovorafenib was evaluated in a multicenter, open-label, single-arm clinical trial (FIREFLY-1; NCT04775485). Individuals received tovorafenib approximately 420 mg/m^2 orally once weekly (range: 290 to 476 mg/m^2) according to body surface area with a maximum dose of 600 mg until disease progression or toxicity. A total of 76 patients were deemed evaluable for efficacy.

The major efficacy outcome measure was overall response rate (ORR), defined as the proportion patients with complete response (CR), partial response (PR), or minor response (MR) by independent review based on RAPNO-LGG (Response Assessment in Pediatric Neuro-Oncology) criteria. Additional efficacy outcome measures were duration of response (DoR), time to response, and ORR based on RANO-LGG (2011) criteria. The median age was 8.5 years (range 2 to 21 years), 53% were male, 53% were White and 26% had no race reported, and 93% had Karnofsky/Lansky performance status of 80 to 100. 59% of patients received prior treatment with a MAP kinase pathway inhibitor, 74% of patients had a KIAA1549:BRAF fusion, 16% had a V600E mutation, and 11% had a BRAF alteration classified as "other" including BRAF duplication or BRAF rearrangement. The ORR was 51% (95% CI 40, 63) with 0 patients having CR, 28 patients having PR, and 11 patients having MR. The median DoR was 13.8 months (95% CI 11.3, not estimable). 85% of patients had observed DoR for greater than at least 6 months, and 23% of patients had observed DoR for greater than at least 12 months.

The safety of tovorafenib was evaluated in 137 patients in FIREFLY-1. Serious adverse reactions occurred in 45% of patients who received tovorafenib. Serious adverse reactions in >2% of patients included viral infection (9%), pneumonia (4%), and sepsis (4%). The most common adverse reactions (≥30%) were rash, hair color changes, fatigue, viral infection, vomiting, headache, hemorrhage, pyrexia, dry skin, constipation, nausea, dermatitis acneiform, and upper

respiratory tract infection. Dosage interruptions due to an adverse reaction occurred in 57% of patients, while dosage reductions due to an adverse reaction occurred in 24% of patients.

Practice Guidelines and Position Statements

National Comprehensive Cancer Network (NCCN)

NCCN guidelines recommend combination BRAF/MEK inhibitor therapy for metastatic or unresectable melanoma with a BRAF V600 activating mutation:

- First-line therapy for BRAF/MEK inhibitors:
    - Dabrafenib/trametinib (category 1)
    - Vemurafenib/cobimetinib (category 1)
    - Encorafenib/binimetinib (category 1)
- Other recommended first-line preferred regimens
    - Combination targeted therapy and immunotherapy with vemurafenib/cobimetinib + atezolizumab (category 2A)
- Second-line or subsequent therapy
    - Dabrafenib/trametinib (category 2A)
    - Vemurafenib/cobimetinib (category 2A)
    - Encorafenib/binimetinib (category 2A)
- Re-induction therapy for individuals who experience disease control (complete response, partial response, or stable disease) and have no residual toxicity, but subsequently experience disease progression/relapse >three months after treatment discontinuation.
- In previously untreated individuals with unresectable American Joint Committee on Cancer 7th Edition stage IIIC or stage IV disease, BRAF/MEK inhibitor combination therapy was associated with improved response rate, PFS, and OS compared to BRAF inhibitor monotherapy

- If BRAF/MEK inhibitor combination therapy is contraindicated, BRAF inhibitor monotherapy is an option, especially in individuals who are not appropriate candidates for checkpoint immunotherapy

2019 Update

Annual review, literature search from 11/1/2018 to 11/1/2019 and reviewed package inserts for medications in this policy. Updated indications for Tafinlar(dabrafenib) and Mekinist (trametinib) per product label. Added monotherapy indication for Tafinlar (dabrafenib), Mekinist (trametinib) and Zelboraf (vemurafenib) for unresectable or metastatic melanoma.

2020 Update

Reviewed prescribing information for all drugs in policy. No new information was identified that would require changes to this policy.

2021 Update

Reviewed prescribing information for all drugs in policy. No new information was identified that would require changes to this policy.

2022 Update

Reviewed prescribing information for all drugs in policy and added a new indication for Tafinlar (dabrafenib) in combination with Mekinist (trametinib) for the treatment of BRAF V600E mutation-positive unresectable or metastatic solid tumors. Reviewed National Comprehensive Cancer Network Guidelines Version 3.2022 Melanoma: Cutaneous on systemic therapy for metastatic or unresectable disease and listed the first line and second line or subsequent therapies.

2023 Update

Reviewed prescribing information for all drugs in policy and added a new indication for Tafinlar (dabrafenib) in combination with Mekinist (trametinib) for the treatment of pediatric individuals 1 year of age and older with low-grade glioma (LGG) with a *BRAF V600E* mutation who require systemic therapy.

2024 Update

Reviewed prescribing information for all drugs in policy and added a new indication for Braftovi (encorafenib) in combination with Mektovi (binimetinib) for the treatment of certain adults with metastatic non-small cell lung cancer (NSCLC). Added coverage for Ojemda (tovorafenib) for the treatment of pediatric individuals ≥6 months and <18 years of age with relapsed or refractory pediatric low-grade glioma (LGG) harboring a BRAF fusion or rearrangement, or BRAF V600 mutation.

2025 Update

Reviewed prescribing information for all drugs in policy and added a new indication for Braftovi (encorafenib) in combination with Erbitux (cetuximab) and mFOLFOX6 for the treatment of metastatic colorectal cancer. Added coverage for Gomekli (mirdametinib) for the treatment of individuals diagnosed with neurofibromatosis type 1 who have symptomatic, inoperable plexiform neurofibromas. Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information. Clarified that non-formulary exception review authorizations for all drugs listed in this policy may be approved up to 12 months.

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History

Date	Comments
11/01/18	New policy, approved October 9, 2018. Add to Prescription Drug section. BRAF and MEK inhibitors are medically necessary for treating unresectable or metastatic melanoma with a BRAF V600E or V600K mutation. Content moved from policy 5.01.534 (Multikinase Inhibitors.) Added two new products, Braftovi and Mektovi. Updated indications per product label.
01/01/20	Annual Review, approved December 17, 2019. Updated coverage criteria for Tafinlar (dabrafenib), Mekinist (trametinib) and Zelboraf (vemurafenib).
06/01/20	Interim Review, approved May 12, 2020. Added Braftovi + Erbitux combination therapy for the treatment of metastatic CRC when criteria are met.
08/01/20	Interim Review, approved July 14, 2020. Added coverage criteria for Koselugo (selumetinib) for the treatment of NF1.
12/01/20	Annual Review, approved November 19, 2020. No changes to policy statements.
11/01/21	Annual Review, approved October 5, 2021. No changes to policy statements.
08/01/22	Annual Review, approved July 12, 2022. Added coverage for Tafinlar (dabrafenib) in combination with Mekinist (trametinib) for the treatment of BRAF V600E mutation-positive unresectable or metastatic solid tumors.
01/01/23	Interim Review, approved December 13, 2022. Added coverage for Cotellic (cobimetinib), as a single agent, for the treatment of adult individuals with histiocytic neoplasms. Changed the wording from "patient" to "individual" throughout the policy for standardization.
06/01/23	Annual Review, approved May 9, 2023. Added a new indication for Tafinlar (dabrafenib) in combination with Mekinist (trametinib) for the treatment of pediatric individuals 1 year of age and older with low-grade glioma (LGG) with a *BRAF V600E* mutation who require systemic therapy.
11/01/23	Interim Review, approved October 23, 2023. Updated coverage for Tafinlar (dabrafenib) in combination with Mekinist (trametinib) from 6 years of age and older to 1 year of age and older for the treatment of solid tumors.

Date	Comments
04/01/24	Annual Review, approved March 12, 2024. Added a new indication for Braftovi (encorafenib) in combination with Mektovi (binimetinib) for the treatment of certain adults with metastatic non-small cell lung cancer (NSCLC).
12/01/24	Interim Review, approved November 12, 2024. Added coverage for Ojemda (tovorafenib) for the treatment of pediatric individuals ≥6 months and <18 years of age with relapsed or refractory pediatric low-grade glioma (LGG) harboring a BRAF fusion or rearrangement, or BRAF V600 mutation. Added a summary of evidence for tovorafenib.
05/01/25	Annual Review, approved April 8, 2025. Added a new indication for Braftovi (encorafenib) in combination with Erbitux (cetuximab) and mFOLFOX6 for the treatment of metastatic colorectal cancer. Added coverage for Gomekli (mirdametinib) for the treatment of neurofibromatosis type 1. Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information. Clarified that non-formulary exception review authorizations for all drugs listed in this policy may be approved up to 12 months.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.