PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Braftovi Prior Authorization Policy
- Braftovi® (encorafenib capsules – Array BioPharma)

REVIEW DATE: 08/14/2024

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. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. 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

Braftovi, a BRAF inhibitor, is indicated for the following uses:[1]
- **Colorectal cancer**, in combination with Erbitux® (cetuximab intravenous infusion), for the treatment of metastatic disease and a *BRAF V600E* mutation, as detected by an FDA-approved test, after prior therapy in adults.
- **Melanoma**, in combination with Mektovi® (binimetinib tablets), for the treatment of unresectable or metastatic disease and a *BRAF V600E* or *V600K* mutation, as detected by an FDA-approved test in adults.
- **Non-small cell lung cancer (NSCLC),** in combination with Mektovi, for the treatment of adult patients with metastatic NSCLC with a *BRAF V600E* mutation, as detected by an FDA-approved test.

It is a limitation of use that Braftovi is not indicated for treatment of patients with wild-type BRAF melanoma, wild-type BRAF colorectal cancer, or wild-type BRAF NSCLC.

Guidelines

National Comprehensive Cancer Network guidelines support use of Braftovi in the following cancers.[5]

- **Colon** and **Rectal Cancer:** Guidelines for colon cancer (version 4.2024 – July 3, 2024) and rectal cancer (version 3.2024 – July 3, 2024) recommend Braftovi for some situations in patients with *BRAF V600E*-mutated disease.[3] For primary treatment (following adjuvant chemotherapy) or as subsequent use, Braftovi + Erbitux or Vectibix® (panitumumab intravenous infusion) is a recommended treatment option. NCCN Compendium recommends the use of Braftovi for appendiceal adenocarcinoma for BRAF V600E mutation-positive disease, as subsequent therapy, in combination with Erbitux or Vectibix.[5]
- **Melanoma, Cutaneous:** Guidelines (version 2.2024 – April 3, 2024) recommend BRAF/MEK inhibitor combinations among the "Preferred" therapies for first-line (category 1) and subsequent treatment (category 2A) of metastatic or unresectable melanoma with a *V600*-activating mutation.[2] The combinations are also recommended for adjuvant treatment (category 2B). While combination BRAF/MEK inhibition is preferred, if a combination is contraindicated, monotherapy with a BRAF inhibitor (Tafinlar® [dabrafenib capsules] or Zelboraf® [vemurafenib tablets]) is a recommended option, especially in patients who are not appropriate candidates for checkpoint immunotherapy.
- **Non-Small Cell Lung Cancer:** Guidelines (version 7.2024 – June 26, 2024) recommend Braftovi + Mektovi and Tafinlar + Mekinist® (trametinib tablets) combinations for first-line "Preferred" regimens and as subsequent therapies (both category 2A) for *BRAF V600E* mutation-positive disease.[6] Zelboraf or Tafinlar monotherapy is also recommended under "Useful in Certain Circumstances" (both category 2A).

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Braftovi. All approvals are provided for the duration noted below.

- **Braftovi® (encorafenib capsules (Array BioPharma)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indications

1. **Colon or Rectal Cancer.** Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has *BRAF V600E* mutation-positive disease; AND
   C) Patient has previously received a chemotherapy regimen for colon or rectal cancer; AND
   Note: Examples of chemotherapy regimens include a fluoropyrimidine such as 5-fluorouracil (5-FU), capecitabine; oxaliplatin, irinotecan, or an adjunctive chemotherapy regimen such as FOLFOX (5-FU, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin).

D) The medication is prescribed as part of a combination regimen for colon or rectal cancer.
Note: Examples of combination regimens include Braftovi + Erbitux (cetuximab intravenous infusion), Braftovi + Vectibix (panitumumab intravenous infusion).

2. Melanoma. Approve for 1 year if the patient meets ALL of the following (A, B, and C):
A) Patient is ≥ 18 years of age; AND
B) Patient has unresectable, advanced, or metastatic melanoma; AND
C) Patient has *BRAF V600* mutation-positive disease.

3. Non-Small Cell Lung Cancer. Approve for 1 year if the patient meets ALL of the following (A, B, and C):
A) Patient is ≥ 18 years of age; AND
B) Patient has *BRAF V600E* mutation-positive metastatic disease; AND
C) The medication will be taken in combination with Mektovi (binimetinib tablets).

Other Uses with Supportive Evidence

4. Appendiceal Adenocarcinoma. Approve for 1 year if the patient meets ALL of the following (A, B, C, and D):
A) Patient is ≥ 18 years of age; AND
B) Patient has *BRAF V600E* mutation-positive disease; AND
C) The medication will be used as subsequent therapy for advanced or metastatic disease; AND
D) The medication will be used in combination with Erbitux (cetuximab intravenous infusion) or Vectibix (panitumumab intravenous infusion).

CONDITIONS NOT COVERED

- **Braftovi® (encorafenib capsules (Array BioPharma)**

is(are) considered experimental, investigational or unproven for ANY other use(s); criteria will be updated as new published data are available.

REFERENCES

1. Braftovi® capsules [prescribing information]. Boulder, CO: Array BioPharma; October 2023.
2. The NCCN Melanoma Clinical Practice Guidelines in Oncology (version 2.2024 – April 3, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org/. Accessed on August 9, 2024.
3. The NCCN Colon Cancer Clinical Practice Guidelines in Oncology (version 4.2024 – July 3, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org/. Accessed on August 9, 2024.
4. The NCCN Rectal Cancer Clinical Practice Guidelines in Oncology (version 3.2024 – July 3, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org/. Accessed on August 9, 2024.
5. The NCCN Drugs & Biologics Compendium. © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on August 9, 2024. Search terms: encorafenib.

6. The NCCN Non-Small Cell Lung Cancer Clinical Practice Guidelines in Oncology (version 7.2024 – June 26, 2024). © 2024 National Comprehensive Cancer Network. Available at: http://www.nccn.org/. Accessed on August 9, 2024.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes	07/19/2023
Selected Revision	**Non-Small Cell Lung Cancer:** Added new FDA-approved indication and criteria	10/18/2023
Annual Revision	**Appendiceal Adenocarcinoma:** Added new approval condition and criteria under "Other Uses with Supportive Evidence" based on compendium/guideline recommendations.	8/14/2024