PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Oral – MEK Inhibitor) – Mekinist Prior Authorization Policy
- Mekinist® (trametinib tablets and oral solution – Novartis)

REVIEW DATE: 08/27/2025

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 WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. 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

Mekinist, a kinase inhibitor, is indicated for the following uses:[1]

- **Low-grade glioma,** in combination with Tafinlar® (dabrafenib capsules and tablets for oral suspension), for the treatment of pediatric patients ≥ 1 year of age with a *BRAF V600E* mutation who require systemic therapy.
- **Melanoma**, in the following situations:
  - As a single agent for unresectable or metastatic disease in BRAF-inhibitor treatment-naïve patients with a *BRAF V600E* or *V600K* mutation as detected by an FDA-approved test.
  - In combination with Tafinlar, for unresectable or metastatic disease with a *BRAF V600E* or *V600K* mutation as detected by an FDA-approved test.
  - In combination with Tafinlar, as adjuvant treatment of *BRAF V600E* or *V600K* mutation-positive disease as detected by an FDA-approved test, with involvement of lymph node(s), following complete resection.

- **Non-small cell lung cancer**, in combination with Tafinlar, for metastatic disease that has the *BRAF V600E* mutation as detected by an FDA-approved test.
- **Solid tumors,** unresectable or metastatic, in combination with Tafinlar, for *BRAF V600E* mutation-positive disease in patients ≥ 1 year of age who have progressed following prior treatment and have no satisfactory alternative treatment options.
- **Thyroid cancer**, in combination with Tafinlar, for locally advanced or metastatic anaplastic disease with *BRAF V600E* mutation, as detected by an FDA-approved test, and with no satisfactory locoregional treatment options.

Limitations of Use: Mekinist is not indicated for treatment of patients with colorectal cancer because of the known intrinsic resistance to BRAF inhibition.[1]

The indication of solid tumors is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.[1]

Guidelines

The National Comprehensive Cancer Network (NCCN) Compendium recommends use of Mekinist for the indications listed in the FDA-Approved Indications and Other Uses with Supportive Evidence sections of this Policy.[2]

POLICY STATEMENT

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

- **Mekinist® (trametinib tablets and oral solution – Novartis)**

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. **Glioma.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   - **A)** Patient meets ONE of the following (i or ii):
     - **i.** Patient has *BRAF V600* mutation-positive disease; OR
     - **ii.** Patient has *BRAF* fusion-positive disease; AND
   - **B)** Patient meets ONE of the following (i or ii):
     - **i.** The medication will be taken in combination with Tafinlar (dabrafenib capsules or tablets for oral suspension); OR
     - **ii.** Patient has circumscribed glioma.

2. **Melanoma.** Approve for 1 year if the patient meets BOTH of the following (A and B):

Note: If patient has uveal melanoma, refer to separate criteria for uveal melanoma.

A) Patient has unresectable, advanced (including Stage III or Stage IV disease), or metastatic melanoma; AND
Note: This includes adjuvant treatment in patients with Stage III disease and no evidence of disease post-surgery.

B) Patient meets ONE of the following (i or ii):
- **i.** Patient has *BRAF* mutation-positive disease; OR
- **ii.** Patient has *BRAF* fusion-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 has recurrent, advanced, or metastatic disease; AND
   - **B)** Patient has *BRAF V600* mutation-positive disease; AND
   - **C)** The medication is prescribed in combination with Tafinlar (dabrafenib capsules or tablets for oral suspension).

4. **Solid Tumors.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   Note: Examples of solid tumors include: biliary tract cancer, brain metastases due to melanoma, differentiated thyroid carcinoma, gastrointestinal stromal tumors, gastric cancer, esophageal and esophagogastric junction cancers, salivary gland tumors, pancreatic adenocarcinoma, neuroendocrine tumors, occult primary, ampullary adenocarcinoma, and small bowel adenocarcinoma.
   - **A)** Patient has *BRAF V600* mutation-positive disease; AND
   - **B)** The medication will be taken in combination with Tafinlar (dabrafenib capsules or tablets for oral suspension).

5. **Thyroid Carcinoma, Anaplastic.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   - **A)** Patient has locally advanced or metastatic anaplastic disease; AND
   - **B)** Patient has *BRAF V600* mutation-positive disease; AND
   - **C)** The medication will be taken in combination with Tafinlar (dabrafenib capsules or tablets for oral suspension).

Other Uses with Supportive Evidence

6. **Epithelioid Hemangioendothelioma**. Approve for 1 year.
7. **Hairy Cell Leukemia.** Approve for 1 year if the patient meets ALL of the following (A, B, and C):
   - **A)** Patient has not been previously treated with a *BRAF* inhibitor therapy; AND
   - **B)** The medication will be used for relapsed/refractory disease; AND
   - **C)** The medication will be taken in combination with Tafinlar (dabrafenib capsules or tablets for oral suspension).

8. **Histiocytic Neoplasm.** Approve for 1 year if the patient meets ONE of the following (A, B, or C):
   - **A)** Patient has Langerhans cell histiocytosis OR

B) Patient has Erdheim-Chester disease; OR
C) Patient has Rosai-Dorfman disease.

9. **Ovarian , Fallopian Tube, or Primary Peritoneal Cancer.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient has recurrent disease; AND
   B) Patient meets ONE of the following (i or ii):
      i. The medication is used for low-grade serous carcinoma; OR
      ii. Patient meets BOTH of the following (a and b):
         a) Patient has *BRAF V600* mutation-positive disease; AND
         b) The medication will be taken in combination with Tafinlar (dabrafenib capsules or tablets for oral suspension).

10. **Uveal Melanoma.** Approve for 1 year if the patient has metastatic or unresectable disease.

CONDITIONS NOT COVERED

- **Mekinist® (trametinib tablets and oral solution – Novartis)**

is(are) considered not medically necessary for ANY other use(s); criteria will be updated as new published data are available.

1. **Colon or Rectal Cancer.** Mekinist is not indicated for the treatment of patients with colorectal cancer because of known intrinsic resistance to BRAF inhibition.[1]

REFERENCES

1. Mekinist® tablets and oral solution [prescribing information]. East Hanover, NJ: Novartis; March 2025.
2. The NCCN Drugs & Biologics Compendium. © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on August 25, 2025. Search term: trametinib.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Melanoma:** Deleted age criterion ≥ 6 years of age. **Non-Small Cell Lung Cancer:** Deleted age criterion ≥ 6 years of age. **Solid Tumors – Unresectable or Metastatic:** Added "occult primary" to the list of examples of solid tumors in the Note. **Thyroid Carcinoma, Anaplastic:** Deleted age criterion ≥ 6 years of age. **Histiocytic Neoplasm:** Deleted age criterion ≥ 6 years of age. **Ovarian, Fallopian Tube, or Primary Peritoneal Cancer:** Deleted age criterion ≥ 6 years of age. **Hairy Cell Leukemia:** Added new indication and criteria based on Compendium recommendations. **Small Bowel Adenocarcinoma:** Added new indication and criteria based on Compendium recommendations.	04/24/2024
Annual Revision	**Low Grade Glioma:** The requirement which states that patient requires systemic therapy was removed. **Melanoma:** A note was added which states "if patient has uveal melanoma, refer to separate criteria for uveal melanoma." **Non-Small Cell Lung Cancer:** The following requirement was added, "patient has recurrent, advanced, or metastatic disease." **Solid tumors:** The following verbiage from the condition of approval "unresectable or metastatic" was removed. The requirement that according to the prescriber, the patient has no satisfactory alternative treatment options was removed. **Thyroid Carcinoma, Anaplastic:** The requirement that **"**the medication is prescribed in combination with Tafinlar (dabrafenib capsules or tablets for oral suspension), unless intolerant" was reworded to, "The medication will be taken in combination with Tafinlar (dabrafenib capsules or tablets for oral suspension)." **Histiocytic Neoplasm:** For a patient that has Langerhans cell histiocytosis, the requirements that the patient has multisystem disease, pulmonary disease, or central nervous system lesions were removed. **Uveal Melanoma:** New condition of approval and criteria were added under Other Uses with Supportive Evidence.	04/09/2025
Update	04/11/2025: The policy name was changed from "Oncology – Mekinist PA Policy" to "Oncology (Oral – MEK Inhibitor) – Mekinist PA Policy."	N/A
Early Annual Revision	**Glioma:** This condition of approval was previously worded as "low-grade glioma." The requirement that the patient is ≥ 1 year of age was removed. An option for approval was added for a patient with *BRAF* fusion-positive disease. An option for approval was added for patient with circumscribed glioma. **Melanoma**: An option for approval was added for a patient with *BRAF* fusion-positive disease. The requirement of "V600" was removed from "*BRAF* mutation." **Solid Tumors**: The requirement that the patient is ≥ 1 year of age was removed. Small bowel adenocarcinoma was added to the Note of examples of a solid tumor. High grade glioma was removed from the Note of examples of solid tumor. **Epithelioid Hemangioendothelioma**. Condition for approval was added to Other Uses with Supportive Evidence. **Small Bowel Adenocarcinoma:** This condition of approval and criteria were removed.	08/27/2025