

Clinical Policy: Encorafenib (Braftovi)

Reference Number: CP.PHAR.127

Effective Date: 09.01.18

Last Review Date: 05.22

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Encorafenib (BraftoviTM) is a kinase inhibitor.

FDA Approved Indication(s)

Braftovi is indicated:

- In combination with binimetinib (Mektovi[®]), for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test.
- In combination with cetuximab, for the treatment of adult patients with metastatic colorectal cancer (CRC) with a BRAF V600E mutation, as detected by an FDA-approved test, after prior therapy

Limitation(s) of use: Braftovi is not indicated for treatment of patients with wild-type BRAF melanoma or wild-type BRAF CRC.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Braftovi is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Melanoma** (must meet all):

1. Diagnosis of melanoma with BRAF V600E or V600K mutation;
2. Disease is for treatment of one of the following (a or b):
 - a. Unresectable or metastatic melanoma;
 - b. Stage III melanoma as adjuvant therapy;
3. Prescribed by or in consultation with an oncologist;
4. Age ≥ 18 years;
5. For unresectable or metastatic melanoma: Prescribed in combination with Mektovi[®], unless Braftovi/Mektovi combination therapy is contraindicated;
6. For adjuvant therapy: Both of the following (a and b):
 - a. Prescribed in combination with Mektovi;
 - b. Member has unacceptable toxicities to Tafinlar[®]/Mekinist[®] or on the basis of agent side-effect profiles;

7. For Braftovi requests, member must use generic encorafenib, if available, unless contraindicated or clinically significant adverse effects are experienced;
8. Request meets one of the following (a or b):*
 - a. Dose does not exceed 450 mg (6 capsules) per day.
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid/HIM – 6 months

Commercial – 12 months or duration of request, whichever is less

B. Colon Cancer, Rectal Cancer (must meet all):

1. Diagnosis of colon cancer or rectal cancer with BRAF V600E mutation;
2. Disease is unresectable, advanced, or metastatic;
3. Prescribed by or in consultation with an oncologist;
4. Age \geq 18 years;
5. Prescribed in combination with either Erbitux[®] or Vectibix[®];
6. One of the following (a or b):
 - a. Member previously received adjuvant therapy (e.g., FOLFOX, CapeOX);
 - b. Request is for subsequent therapy following previous treatment (e.g., oxaliplatin- or irinotecan-based therapy, Opdivo[®], Keytruda[®]);
7. For Braftovi requests, member must use generic encorafenib, if available, unless contraindicated or clinically significant adverse effects are experienced;
8. Request meets one of the following (a or b):*
 - a. Dose does not exceed 300 mg (4 capsules) per day;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid/HIM – 6 months

Commercial – 12 months or duration of request, whichever is less

C. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line

of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Braftovi for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For Braftovi requests, member must use generic encorafenib, if available, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, request meets one of the following (a, b, or c):*
 - a. Melanoma: New dose does not exceed 450 mg (6 capsules) per day;
 - b. Colon or rectal cancer: New dose does not exceed 300 mg (4 capsules) per day;
 - c. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration:

Medicaid/HIM – 12 months

Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- ### **A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies –**
- CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

BRAF: B-Raf proto-oncogene, serine/threonine kinase

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<i>Colorectal Cancer</i>		
FOLFOX (fluorouracil, leucovorin, and oxaliplatin); CapeOX (capecitabine and oxaliplatin); FOLFIRI (irinotecan, leucovorin, 5-FU); FOLFOXIRI (irinotecan, oxaliplatin, leucovorin, fluorouracil); IROX (oxaliplatin, irinotecan); oxaliplatin and irinotecan	Varies	Varies
Opdivo (nivolumab)	Monotherapy: 240 mg IV every 2 weeks or 480 mg IV every 4 weeks With ipilimumab: 3 mg/kg IV, followed by ipilimumab 1 mg/kg on the same day every 3 weeks for 4 doses, then nivolumab 240 mg IV every 2 weeks or 480 mg IV every 4 weeks	Monotherapy: 480 mg/dose With ipilimumab: 3 mg/kg/dose
Keytruda (pembrolizumab)	200 mg IV every 3 weeks OR 400 mg every 6 weeks up to 24 months	200 mg every 3 weeks OR 400 mg every 6 weeks
<i>Melanoma</i>		
Tafinlar [®] and Mekinist [®]	Tafinlar 150 mg PO BID with Mekinist 2 mg PO QD	Tafinlar: 300 mg/day Mekinist: 2 mg

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Melanoma	450 mg PO QD in combination with Mektovi until disease progression or unacceptable toxicity	450 mg per day
Colon cancer, rectal cancer	300 mg PO QD with either Erbitux	300 mg per day

VI. Product Availability

Capsule: 75 mg

VII. References

1. Braftovi Prescribing Information. Boulder, CO: Array BioPharma Inc.; February 2022. Available at: <https://www.braftovimektovi.com/>. Accessed April 15, 2022.
2. National Comprehensive Cancer Network. Cutaneous Melanoma Version 2.2022. Available at: https://www.nccn.org/professionals/physician_gls/pdf/cutaneous_melanoma.pdf. Accessed February 12, 2022.
3. National Comprehensive Cancer Network. Colon Cancer Version 1.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf. Accessed February 12, 2022.
4. National Comprehensive Cancer Network. Rectal Cancer Version 1.2021. Available at: https://www.nccn.org/professionals/physician_gls/pdf/rectal.pdf. Accessed February 12, 2022.
5. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed February 12, 2022.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	07.24.18	08.18
No significant changes: added HIM line of business per SDC.	10.23.18	
2Q 2019 annual review: no significant changes; references reviewed and updated.	02.26.19	05.19
2Q 2020 annual review: RT4: added newly FDA-approved and NCCN compendium supported use in colon and rectal cancers in combination with either Erbitux or Vectibix; added maximum quantity for all indications; references reviewed and updated.	02.06.20	05.20
2Q 2021 annual review: oral oncology generic redirection language added; revised reference to HIM off-label use policy from HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	01.12.21	05.21
2Q 2022 annual review: for melanoma, added option for Braftovi monotherapy in melanoma if Mektovi is contraindicated and adjuvant therapy category 2A indication per NCCN; Commercial approval durations revised from “Length of Benefit” to “12 months or duration of request, whichever is less”; references reviewed and updated.	02.12.22	05.22
Template changes applied to other diagnoses/indications.	09.30.22	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

©2018 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene[®] and Centene Corporation[®] are registered trademarks exclusively owned by Centene Corporation.