

Generic Name: Encorafenib

Therapeutic Class or Brand Name: Braftovi

Applicable Drugs (if Therapeutic Class): N/A

GPI Code: 2153204000

Preferred: N/A

Non-preferred: N/A

Date of Origin: 1/9/2019

Date Last Reviewed / Revised: 1/9/2019

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through V are met)

- I. Documented diagnosis of unresectable or metastatic melanoma.
- II. Documentation of BRAF V600E or V600K mutations as detected by an FDA-approved test.
- III. Braftovi will be used in combination with Mektovi® (binimetinib).
- IV. Minimum age requirement: 18 years old.
- V. Prescribing physician is an oncologist.

EXCLUSION CRITERIA

- Not indicated for treatment of wild-type BRAF melanoma.

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- Up to a maximum of 450mg once daily (6 capsules per day) for a 30 day supply.

APPROVAL LENGTH

- **Authorization:** 6 months.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and the medication is effective.

APPENDIX

N/A

REFERENCES

1. <https://www.premera.com/medicalpolicies/5.01.589.pdf>.

2. Medi-Span®
3. http://www.arraybiopharma.com/documents/Braftovi_Prescribing_information.pdf.

HISTORICAL TRACKING OF CHANGES MADE TO POLICY

| Date | Notes/Changes |
|----------|----------------|
| 1/9/2019 | 1. New Policy. |

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.