Clinical Policy: Trametinib (Mekinist)

Reference Number: CP.PHAR.240
Effective Date: 07.01.16
Last Review Date: 08.18
Line of Business: Commercial, HIM, Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Trametinib (Mekinist®) is a kinase inhibitor.

FDA Approved Indication(s)

Mekinist is indicated:

- As a single agent for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test
- In combination with dabrafenib:
  - For the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test
  - For the adjuvant treatment of patients with melanoma with BRAF V600E or V600K mutations, as detected by an FDA-approved test, and involvement of lymph node(s), following complete resection
  - For the treatment of patients with metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test
  - For the treatment of patients with locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and with no satisfactory locoregional treatment options

Limitation(s) of use: Mekinist is not indicated for treatment of patients with melanoma who have progressed on prior BRAF-inhibitor therapy.

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 Mekinist 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. Member meets one of the following (a or b), disease is:
   a. Unresectable or metastatic;
   b. Presence of lymph node(s) involvement following complete resection;
3. Prescribed by or in consultation with an oncologist;
4. Age ≥ 18 years;

5. Dose does not exceed 2 mg/day (1 tablet/day).

Approval duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

B. Non-Small Cell Lung Cancer (must meet all)**:**
1. Diagnosis of metastatic or recurrent NSCLC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Positive for a BRAF V600E mutation;
5. Mekinist will be used in combination with Tafinlar®;
6. Dose does not exceed 2 mg/day (1 tablet/day).

Approval duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

C. Anaplastic Thyroid Cancer (ATC) (must meet all)**:**
1. Diagnosis of ATC;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Positive for a BRAF V600E mutation;
5. Mekinist will be used in combination with Tafinlar;
6. Dose does not exceed 2 mg/day (1 tablet/day).

Approval duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

D. Uveal Melanoma (off-label) (must meet all)**:**
1. Diagnosis of metastatic or unresectable uveal melanoma;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 18 years;
4. Dose does not exceed 2 mg/day (1 tablet/day).

Approval Duration:
Medicaid/HIM – 6 months
Commercial – Length of Benefit

E. Other diagnoses/indications
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 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 Mekinist for melanoma, ATC, or NSCLC and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 2 mg/day (1 tablet/day).

Approval duration:
Medicaid/HIM – 12 months
Commercial – Length of Benefit

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 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.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
ATC: anaplastic thyroid cancer
BRAF: B-Raf proto-oncogene serine/threonine kinase
FDA: Food and Drug Administration
NSCLC: non-small cell lung cancer

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications
Not applicable

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Melanoma, NSCLC, ATC	2 mg PO QD at least 1 hour before or at least 2 hours after a meal	2 mg/day

VI. Product Availability

Tablets: 0.5 mg, 2 mg

VII. References

1. Mekinist Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; May 2018. Available at www.pharma.us.novartis.com/product/pi/pdf/mekinist.pdf. Accessed May 11, 2018.
2. Trametinib. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at NCCN.org. Accessed January 27, 2018.
3. Melanoma (Version 2.2018). In: National Comprehensive Cancer Network Guidelines. Available at NCCN.org. Accessed January 27, 2018.
4. Non-Small Cell Lung Cancer (Version 2.2018). In: National Comprehensive Cancer Network Guidelines. Available at NCCN.org. Accessed January 27, 2018.
5. Thyroid Carcinoma (Version 2.2018). In: National Comprehensive Cancer Network Guidelines. Available at NCCN.org. Accessed May 11, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.117.Mekinist and Tafinlar and converted to new template. No generics available. Age requirement removed. NCCN compendial uses for melanoma are covered within the scope of the FDA approved uses; the remaining NCCN uses for NSCLC are added.	06.16	07.16
Safety criteria is revised according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs. Removed the following for initial criteria: disease has not progressed on prior BRAF-inhibitor therapy (e.g., Zelboraf, Tafinlar), if prior BRAF-inhibitor therapy was used. Added criteria for new FDA approved indication NSCLC.	06.17	07.17
2Q 2018 annual review: no significant changes; policies combined for Commercial and Medicaid; added age; summarized NCCN and FDA approved uses for improved clarity; added specialist involvement in care; added continuity of care statement and updated approval duration from 3/6 to 6/12 months for Medicaid; references reviewed and updated.	02.06.18	05.18
Updated criteria with new indications for anaplastic thyroid cancer and the adjuvant treatment of melanoma following complete lymph node(s) resection; added off-label use for uveal melanoma; added TBD-HIM line of business.	05.29.18	08.18

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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.