PRIOR AUTHORIZATION POLICY

POLICY: Oncology (Oral – MEK Inhibitor) – Mektovi Prior Authorization Policy
- Mektovi® (binimetinib tablets – Array BioPharma)

REVIEW DATE: 08/20/2025

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

Mektovi, a MEK inhibitor, is indicated for the following uses: [1]

- **Melanoma,** in combination with Braftovi® (encorafenib capsules) for the treatment of unresectable or metastatic disease in patients with a *BRAF V600E* or *V600K* mutation, as detected by an FDA-approved test.
- **Non-small cell lung cancer (NSCLC),** in combination with Braftovi, for the treatment of metastatic NSCLC in adults with a *BRAF V600E* mutation, as detected by an FDA-approved test.

Guidelines

National Comprehensive Cancer Network guidelines support use of Mektovi in the following cancers.

- **Histiocytic Neoplasms:** NCCN guidelines (version 1.2025 – June 20, 2025) recommend Mektovi as one of the "Other Recommended Regimens" (category 2A) for histiocytic neoplasms (if there is a MAP kinase pathway

mutation, or no detectable mutation, or testing is not available) for Langerhans cell histiocytosis (including multisystem, pulmonary, bone disease, central nervous system lesions, or relapsed or refractory disease).[3]

- **Melanoma, Cutaneous:** NCCN guidelines (version 2.2025 – January 28, 2025) 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 *BRAF V600* activating mutation.[2] This combination is also recommended for adjuvant treatment (category 2B). While combination BRAF/MEK inhibition is preferred, if a combination is contraindicated, monotherapy with a BRAF inhibitor is an option, especially in patients who are not appropriate candidates for checkpoint immunotherapy. Mektovi is recommended as "Useful in Certain Circumstances" as a single agent for *NRAS*-mutated tumors for progression following immune checkpoint inhibitor therapy (category 2B)
- **NSCLC:** NCCN guidelines (version 8.2025 – August 15, 2025) recommend Braftovi + Mektovi and Tafinlar® (dabrafenib capsules) + Mekinist® (trametinib tablets) for first-line "Preferred" regimens and as subsequent therapies (both category 2A) for *BRAF V600E* mutation-positive recurrent, advanced, or metastatic disease.[4] Zelboraf® (vemurafenib tablets) 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 Mektovi. All approvals are provided for the duration noted below.

- **Mektovi® (binimetinib tablets – 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. **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 meets ONE of the following (i or ii):
      i. Patient meets BOTH of the following (a and b):
         a) Patient has *BRAF V600* mutation-positive disease; AND
         b) The medication will be used in combination with Braftovi (encorafenib capsules); OR
      ii. Patient meets BOTH of the following (a and b):
         a) Patient has a NRAS mutation; AND
         b) Patient has tried at least one immune checkpoint inhibitor therapy. Note: Examples of immune checkpoint inhibitors include: Opdivo (nivolumab intravenous infusion), Opdualag (nivolumab/relatlimab-

rmbw intravenous infusion), Keytruda (pembrolizumab intravenous infusion), and Yervoy (ipilimumab intravenous infusion).

2. **Non-Small Cell Lung 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 recurrent, advanced, or metastatic disease; AND
   C) Patient has *BRAF V600E* mutation-positive disease; AND
   D) The medication will be used in combination with Braftovi (encorafenib capsules).

Other Uses with Supportive Evidence

3. **Histiocytic Neoplasm.** Approve for 1 year if the patient meets BOTH of the following (A and B):
   A) Patient is ≥ 18 years of age; AND
   B) Patient has Langerhans cell histiocytosis.

CONDITIONS NOT COVERED

- **Mektovi® (binimetinib tablets – Array BioPharma)**

is(are) considered not medically necessary for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as newly published data are available):

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as newly published data are available.

REFERENCES

1. Mektovi® tablets [prescribing information]. Boulder, CO: Array BioPharma; October 2023.
2. The NCCN Melanoma Clinical Practice Guidelines in Oncology (version 2.2025 – January 28, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on August 15, 2025.
3. The NCCN Histiocytic Neoplasms Clinical Practice Guidelines in Oncology (version 1.2025 – June 20, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on August 15, 2025.
4. The NCCN Non-Small Cell Lung Cancer Clinical Practice Guidelines in Oncology (version 8.2025 – August 15, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on August 15, 2025.

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	No criteria changes	08/14/2024

Update	04/08/2025: The policy name was changed from "Oncology – Mektovi PA Policy" to "Oncology (Oral - MEK Inhibitor) – Mektovi PA Policy"	N/A
Annual Revision	**Melanoma**: An option for approval was added for a patient with a NRAS mutation who has tried at least one immune checkpoint inhibitor therapy. A Note was added with examples of immune checkpoint inhibitors. **Non-Small Cell Lung Cancer:** An option for approval was added if the patient has recurrent or advanced disease. **Histiocytic Neoplasm:** The requirement that the patient has multisystem disease, pulmonary disease, or central nervous system lesions was removed.	08/20/2025