

<b>Clinical Policy Title:</b>	trametinib
<b>Policy Number:</b>	RxA.216
<b>Drug(s) Applied:</b>	Mekinist®
<b>Original Policy Date:</b>	03/06/2020
<b>Last Review Date:</b>	12/11/2025
<b>Line of Business Policy Applies to:</b>	All lines of business (except Medicare)

## Criteria

### I. Initial Approval Criteria

#### A. Anaplastic Thyroid Cancer (must meet all):

1. Diagnosis of locally advanced or metastatic ATC with BRAF V600E mutation;
2. Prescribed in combination with Tafinlar (dabrafenib).

##### Approval Duration

**All Lines of Business (except Medicare):** 12 months

#### B. Melanoma (must meet all):

1. Diagnosis of melanoma with BRAF V600E or V600K mutation;
2. Member meets one of the following (a or b):
  - a. Disease is unresectable or metastatic;
  - b. Presence of lymph node involvement following complete resection;
3. Member meets one of the following (a or b):
  - a. Prescribes a single agent in BRAF-inhibitor treatment naïve patients
  - b. Prescribed in combination with Tafinlar (dabrafenib).

##### Approval Duration

**All Lines of Business (except Medicare):** 12 months

#### C. Non-Small Cell Lung Cancer (must meet all):

1. Diagnosis of unresectable or metastatic NSCLC with BRAF V600E mutation;
2. Prescribed in combination with Tafinlar (dabrafenib).

##### Approval Duration

**All Lines of Business (except Medicare):** 12 months

#### D. Solid Tumor (must meet all):

1. Diagnosis of unresectable or metastatic solid tumor with BRAF V600E mutation;
2. Disease has progressed on prior treatment, and no satisfactory alternative treatment options are available;
3. Prescribed in combination with Tafinlar (dabrafenib).

##### Approval Duration

**All Lines of Business (except Medicare):** 12 months

#### E. Pediatric Low-Grade Glioma (LGG) (must meet all):

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

1. Diagnosis of LGG with BRAF V600E mutation;
2. Prescribed in combination with Tafenlar (dabrafenib).

**Approval Duration**

**All Lines of Business (except Medicare):** 12 months

**II. Continued Therapy Approval**

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

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

**Approval Duration**

**All Lines of Business (except Medicare):** 12 months

**References**

1. National Comprehensive Cancer Network. Cutaneous Melanoma Version 2.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/cutaneous\\_melanoma.pdf](https://www.nccn.org/professionals/physician_gls/pdf/cutaneous_melanoma.pdf). Accessed August 28, 2024.
2. National Comprehensive Cancer Network. Central Nervous System Cancers Version 1.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/cns.pdf](https://www.nccn.org/professionals/physician_gls/pdf/cns.pdf). Accessed August 28, 2024.
3. National Comprehensive Cancer Network Guidelines. Non-Small Cell Lung Cancer Version 8.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/nscl.pdf](https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf). Accessed August 28, 2024.
4. National Comprehensive Cancer Network Guidelines. Thyroid Carcinoma Version 4.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/thyroid.pdf](https://www.nccn.org/professionals/physician_gls/pdf/thyroid.pdf). Accessed August 28, 2024.
5. National Comprehensive Cancer Network Guidelines. Colon Cancer Version 5.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/colon.pdf](https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf). Accessed August 28, 2024.
6. National Comprehensive Cancer Network Guidelines. Ovarian Cancer including Fallopian Tube Cancer and Primary Peritoneal Cancer Version 3.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/ovarian.pdf](https://www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf). Accessed August 28, 2024.
7. National Comprehensive Cancer Network Guidelines. Rectal Cancer Version 4.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/rectal.pdf](https://www.nccn.org/professionals/physician_gls/pdf/rectal.pdf). Accessed August 28, 2024.
8. National Comprehensive Cancer Network Guidelines. Ampullary adenocarcinoma Version 2.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/ampullary.pdf](https://www.nccn.org/professionals/physician_gls/pdf/ampullary.pdf). Accessed August 28, 2024.
9. National Comprehensive Cancer Network Guidelines. Esophageal and Esophagogastric Junction Cancers Version 4.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/esophageal.pdf](https://www.nccn.org/professionals/physician_gls/pdf/esophageal.pdf). Accessed August 28, 2024.
10. National Comprehensive Cancer Network Guidelines. Gastric Cancer Version 4.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/gastric.pdf](https://www.nccn.org/professionals/physician_gls/pdf/gastric.pdf). Accessed August 28, 2024.
11. National Comprehensive Cancer Network Guidelines. Gastrointestinal Stromal Tumors Version 2.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/gist.pdf](https://www.nccn.org/professionals/physician_gls/pdf/gist.pdf). Accessed August 28, 2024.
12. National Comprehensive Cancer Network Guidelines. Neuroendocrine and Adrenal Tumors Version 2.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/neuroendocrine.pdf](https://www.nccn.org/professionals/physician_gls/pdf/neuroendocrine.pdf). Accessed August 28, 2024.
13. National Comprehensive Cancer Network Guidelines. Pancreatic Adenocarcinoma Version 3.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/pancreatic.pdf](https://www.nccn.org/professionals/physician_gls/pdf/pancreatic.pdf). Accessed August 28, 2024.
14. National Comprehensive Cancer Network Guidelines. Pediatric Central Nervous System Cancers Version 1.2024. Available at: [https://www.nccn.org/professionals/physician\\_gls/pdf/ped\\_cns.pdf](https://www.nccn.org/professionals/physician_gls/pdf/ped_cns.pdf). Accessed August 28, 2024.

Review/Revision History	Review/Revision Date	P&T Approval Date
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Policy established.	02/2020	03/06/2020
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Initial therapy criteria: Dosing criteria updated for all off-label indications.</li> <li>2. IT therapy criteria- Approval duration updated for commercial from 6 months to 12 months</li> <li>3. Continued Therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance..."</li> <li>4. Removed recurrent from disease criteria</li> <li>5. Reference reviewed and updated.</li> </ol>	06/26/2020	09/14/2020
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Clinical Policy Title was updated.</li> <li>2. Initial Approval Criteria was updated to reflect current off- label indications.</li> <li>3. Initial duration of approval updated.</li> <li>4. Continued Therapy criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance..."</li> <li>5. References were updated.</li> </ol>	04/19/2021	06/10/2021
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Initial Approval Criteria I.B.5: Updated from Prescribed in combination with dabrafenib to Member meets one of the following (a or b): <ol style="list-style-type: none"> <li>a. As a single agent in BRAF-inhibitor treatment naïve patients</li> <li>b. Prescribed in combination with dabrafenib;</li> </ol> </li> <li>2. Initial Approval Criteria I.D.1.b: Updated to remove Diagnosis of CNS cancer with brain metastases as (i, ii, or iii): <ol style="list-style-type: none"> <li>i. Initial treatment in members with small asymptomatic brain metastases;</li> <li>ii. Treatment for recurrent brain metastases;</li> <li>iii. Treatment of relapsed disease with either stable systemic disease or reasonable systemic treatment options;</li> </ol> </li> <li>3. Initial Approval Criteria I.D.1.b: Updated to add Recurrent disease for one of the following conditions: (i, ii, or iii): <ul style="list-style-type: none"> <li>Low-grade glioma;</li> <li>Anaplastic glioma;</li> <li>Glioblastoma;</li> </ul> </li> <li>4. Initial Approval Criteria I.D.1.c: Updated to add Brain metastases from melanoma;</li> <li>5. Initial Approval Criteria I.G.2: Updated to remove Prescribe as monotherapy (a, b, c, d, or e):</li> </ol>	01/19/2022	04/18/2022

<ul style="list-style-type: none"> <li>a. As immediate treatment for serially rising CA-125 in patients that previously received chemotherapy;</li> <li>b. For progression on primary, maintenance, or recurrence therapy (platinum-resistant disease);</li> <li>c. For stable or persistent disease (if not on maintenance therapy) (platinum-resistant disease);</li> <li>d. For complete remission and relapse less than 6 months after completing chemotherapy (platinum resistant disease);</li> <li>e. For radiographic and/or clinical relapse in members with previous complete remission and relapse 6 months or greater after completing prior chemotherapy (platinum-sensitive disease)</li> <li>6. Initial Approval Criteria I.G.2. was updated: Prescribe as monotherapy for platinum sensitive or platinum resistant recurrence</li> <li>7. Continued Therapy Approval Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...".</li> <li>8. References were reviewed and updated.</li> </ul>		
<p>Policy was reviewed:</p> <ul style="list-style-type: none"> <li>1. Initial Approval Criteria, I.D: Updated to include approval criteria for indication, BRAF V600E Mutation-Positive Unresectable or Metastatic Solid Tumors.</li> <li>2. References were reviewed and updated.</li> </ul>	09/15/2022	10/19/2022
<p>Policy was reviewed:</p> <ul style="list-style-type: none"> <li>1. Initial Approval Criteria, I.A.1: Updated to include new diagnosis criteria locally advanced, unresectable, or metastatic ATC.</li> <li>2. Initial Approval Criteria, I.D.6.a.iv: Updated to include new dosing criteria Pediatric patients &lt; 26 kg: Refer to dosing information.</li> <li>3. Initial Approval Criteria, I.E: Updated to include approval criteria for indication, Pediatric Low-Grade Glioma.</li> <li>4. Initial Approval Criteria, I.A.4, I.B.5.b, I.C.4, I.D.5, I.F.4: Updated combination therapy criteria from Prescribed in combination with dabrafenib to Prescribed in combination with Tafinlar (dabrafenib).</li> <li>5. Initial Approval Criteria, I.F.5.b.ii, I.F.5.b.iii: Updated to include new diagnosis criteria Oligodendroglioma and Isocitrate dehydrogenase-2 (IDH2)-mutant astrocytoma.</li> <li>6. Initial Approval Criteria, I.H.1: Updated diagnostic criteria from Diagnosis of histiocytic neoplasms to</li> </ul>	05/05/2023	07/13/2023

<p>Diagnosis of histiocytic neoplasms positive for mitogen-activated protein (MAP) kinase pathway mutation, or no detectable mutation, or testing not available; (a, b, or c);</p> <ol style="list-style-type: none"> <li>a. Erdheim-Chester disease;</li> <li>b. Langerhans Cell histiocytosis;</li> <li>c. Rosai Dorfman disease;</li> </ol> <p>7. Initial Approval Criteria, I.H.2: Updated to remove prior diagnostic criteria " Trametinib is used as first-line or subsequent therapy for mitogen-activated protein (MAP) kinase pathway mutation, or no detectable mutation, or testing not available, as a single agent for (a, b, c, d, e, f, or g):</p> <ol style="list-style-type: none"> <li>a. Multisystem Langerhans Cell Histiocytosis (LCH) with symptomatic or impending organ dysfunction;</li> <li>b. Pulmonary LCH;</li> <li>c. LCH with multifocal single system bone disease not responsive to treatment with a bisphosphonate and greater than 2 lesions;</li> <li>d. LCH with CNS lesions;</li> <li>e. Symptomatic Erdheim-Chester Disease (ECD);</li> <li>f. Symptomatic, unresectable Rosai-Dorfman Disease (RDD), unifocal or multifocal; or</li> <li>g. Relapsed/refractory disease ECD, LCH, or RDD;"</li> </ol> <p>8. Initial Approval Criteria, I.H.4: Updated to add single agent therapy Prescribed as a single agent.</p> <p>9. Initial Approval Criteria, I.I.1: Updated diagnostic criteria from Diagnosis of persistent or low-grade serous epithelial ovarian, fallopian tube, or primary peritoneal cancer to Diagnosis of persistent or low-grade serous epithelial ovarian, fallopian tube, or primary peritoneal cancer with BRAF V600E positive mutation</p> <p>10. Initial Approval Criteria, I.I.4: Updated to add new combination therapy Medication is used for one (1) of the following situations (a or b):</p> <ol style="list-style-type: none"> <li>a. Used in combination with Tafinlar (dabrafenib) for recurrent, advanced, or metastatic disease;</li> <li>b. Prescribed for platinum sensitive or platinum resistant recurrence with or without Tafinlar (dabrafenib);</li> </ol> <p>11. Initial Approval Criteria, I.F.6, I.G.6, I.H.5, I.I.5, I.J.5: Updated dosing criteria from Request meets one of the following (a or b):</p> <ol style="list-style-type: none"> <li>a. Dose does not exceed 2 mg/day ;</li> <li>b. Dose is supported by practice guidelines or peer reviewed literature for the relevant off-</li> </ol>		
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<p>label use (prescriber must submit supporting evidence) to Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).</p> <p>12. Initial Approval Criteria, I.K: Updated to include approval criteria for indication, Cutaneous Melanoma</p> <p>13. Initial Approval Criteria, I.L: Updated to include approval criteria for indication, Ampullary adenocarcinoma.</p> <p>14. Initial Approval Criteria, I.M: Updated to include approval criteria for indication, Esophageal and Esophagogastric Junction Cancers.</p> <p>15. Initial Approval Criteria, I.N: Updated to include approval criteria for indication, Gastric Cancer.</p> <p>16. Initial Approval Criteria, I.O: Updated to include approval criteria for indication, Gastrointestinal Stromal Tumors .</p> <p>17. Initial Approval Criteria, I.P: Updated to include approval criteria for indication, Neuroendocrine and Adrenal Tumors .</p> <p>18. Initial Approval Criteria, I.Q: Updated to include approval criteria for indication, Pancreatic Cancer.</p> <p>19. Initial Approval Criteria, I.R: Updated to include approval criteria for indication, Pediatric Central Nervous System (CNS) Cancers.</p> <p>20. References were reviewed and updated.</p>		
<p>Policy was reviewed.</p>	10/19/2023	10/19/2023
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Removed age restrictions.</li> <li>2. Removed prescriber restrictions.</li> <li>3. Removed dose restrictions.</li> <li>4. Updated continued therapy approval with auto-approval based on lookback functionality within the past 120 days.</li> <li>5. Removed reauthorization requirement for positive response to therapy.</li> <li>6. Updated approval duration verbiage.</li> <li>7. References were reviewed and updated.</li> </ol>	08/28/2024	09/13/2024
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Off label indications removed.</li> </ol>	12/05/2024	N/A

Policy reviewed.	12/11/2025	12/11/2025
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