Reference number(s)
5434-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	☑
Standard Control – Choice (SCCF)	☑
Preferred Drug Plan Design (PDPD)	☐
Advanced Control Specialty (ACSF)	☑
Advanced Control Specialty – Choice (ACSCF)	☑
Managed Medicaid Template (MMT)	☐
Marketplace (MF)	☐
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	☐
Aetna Individual Lives (IVL)	☐
Value (VF)	☑

Formulary	Applies
New to Market (NTM)	☐
Standard Formulary Chart (SFC)	☐
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	☐
Advanced Control Specialty Formulary Chart (ACSFC)	☐
Value Formulary Chart (VFC)	☐
Medical Benefit	☐
Medical Benefit: Advanced Biosimilars First	☐
Medical Benefit: Managed Medicaid (MMMB)	☐
Medicare Part B	☐
Medicare Part B: Advanced Biosimilars First	☐

Exceptions Criteria
Cutaneous Melanoma

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Standard Control Formulary (SF), Standard Control Choice Formulary (SCCF), Advanced Control Specialty Formulary (ACSF), Advanced Control Specialty – Choice Formulary (ACSCF), and Value Formulary (VF).

Plan Design Summary

This program applies to the cutaneous melanoma products specified in this document. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to members who are new to treatment with a targeted product for the first time.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. BRAF/MEK Inhibitors

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Products
Preferred	BRAF Inhibitors: • Braftovi (encorafenib) • Tafinlar (dabrafenib)
Preferred	MEK Inhibitors: • Mekinist (trametinib) • Mektovi (binimetinib)
Targeted	BRAF Inhibitor: • Zelboraf (vemurafenib)
Targeted	MEK Inhibitor: • Cotellic (cobimetinib)

Exception Criteria

This program applies to members requesting treatment for cutaneous melanoma.

Coverage for a targeted product is provided when any of the following criteria is met:

- Member is currently receiving treatment with a targeted product, excluding when the requested targeted product is obtained as samples or via manufacturer's patient assistance programs.
- Member has a documented inadequate response or intolerable adverse event with both of the preferred products with the same mechanism of action as the requested product(s).

References

1. Braftovi [package insert]. Boulder, CO: Array BioPharma, Inc.; February 2022.
2. Cotellic [package insert]. South San Francisco, CA: Genentech USA, Inc.; May 2023.
3. Mekinist [package insert]. East Hanover, NJ: Novartis Pharmaceutical Corporation; August 2023.
4. Mektovi [package insert]. Boulder, CO: Array BioPharma, Inc.; October 2020.
5. Tafinlar [package insert]. East Hanover, NJ: Novartis Pharmaceutical Corporation; August 2023.
6. Zelboraf [package insert]. South San Francisco, CA: Genentech USA, Inc.; May 2020.
7. The NCCN Drugs & Biologics Compendium 2025 National Comprehensive Cancer Network, Inc. https://www.nccn.org. Accessed January 30, 2025.
8. National Comprehensive Cancer Network. NCCN Clinical Practice Guidelines in Oncology: Melanoma: Cutaneous. Version 2.2025. https://www.nccn.org/professionals/physician_gls/pdf/cutaneous_melanoma.pdf. Accessed January 30, 2025.

