UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1062-16
Program	Prior Authorization/Notification
Medication	Mekinist® (trametinib)
P&T Approval Date	7/2013, 2/2014, 5/2014, 5/2015, 5/2016, 3/2017, 3/2018, 3/2019, 3/2020, 3/2021, 3/2022, 8/2022, 5/2023, 5/2024, 5/2025
Effective Date	8/1/2025

1. Background:

Mekinist® (trametinib) is a kinase inhibitor indicated as a single agent or in combination with Tafinlar® (dabrafenib) for treatment of patients with unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutations as detected by an FDA-approved test. It is also indicated in combination with Tafinlar for the treatment of metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA approved test, for the adjuvant treatment of melanoma with BRAF V600E or BRAF V600K mutations, as detected by an FDA-approved test, involving the lymph nodes following resection, for the treatment of locally advanced or metastatic anaplastic thyroid cancer with BRAF V600E mutation with no satisfactory locoregional treatment options, and for the treatment of adult and pediatric patients 1 year of age and older with unresectable or metastatic solid tumors with BRAF V600E mutation who have progressed following prior treatment and have no satisfactory alternative treatment options. The latter indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s). Mekinist, in combination with Tafinlar, is also indicated for the treatment of pediatric patients 1 year of age and older with low-grade glioma (LGG) with a BRAF V600E mutation who require systemic therapy.

The National Comprehensive Cancer Network (NCCN) also recommends use of Mekinist in combination with Tafinlar for the adjuvant treatment of anaplastic thyroid cancer with BRAF V600E mutations following resection; for the treatment of follicular, oncocytic, and papillary thyroid carcinomas with a BRAF mutation; for the treatment of central nervous system (CNS) cancer in patients with melanoma or infiltrative supratentorial astrocytoma/oligodendroglioma; distant metastatic uveal melanoma; epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer with persistent disease, recurrence in BRAF V600E positive tumors, or recurrence of low-grade serous carcinoma; pancreatic and ampullary adenocarcinomas if BRAF V600E mutation positive; BRAF V600E mutation positive histiocytic neoplasms and hepatobiliary cancers; hairy cell leukemia; salivary gland tumor; and gastrointestinal stromal tumor.
Information on FDA-approved tests for the detection of BRAFV600 mutations in melanoma may be found at: http://www.fda.gov/CompanionDiagnostics.

Coverage Information:

Members will be required to meet the criteria below for coverage. For members under the age of 19 years, the prescription will automatically process without a coverage review.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

2. Coverage Criteria[a]:

A. Patients less than 19 years of age

1. **Mekinist** will be approved based on the following criterion:

   a. Patient is less than 19 years of age

   Authorization will be issued for 12 months.

B. Melanoma

1. **Initial Authorization**

   a. **Mekinist** will be approved based on **one** of the following criteria:

      (1) **Both** of the following:

         (a) **One** of the following:

            i. Unresectable melanoma

            ii. Metastatic melanoma

            iii. **Both** of the following:

               - Prescribed as adjuvant therapy for melanoma involving the lymph node(s)

               -AND-

               - Used in combination with Tafinlar (dabrafenib)

         -AND-

         (b) Cancer is positive for BRAF V600 mutation

      -OR-

      (2) Distant metastatic uveal melanoma

   Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Mekinist** will be approved based on the following criterion:

      (1) Patient does not show evidence of progressive disease while on Mekinist therapy

   Authorization will be issued for 12 months.

C. Non-Small Cell Lung Cancer (NSCLC)

1. **Initial Authorization**

a. **Mekinist** will be approved based on **all** of the following criteria:

(1) Diagnosis of non-small cell lung cancer (NSCLC)

-AND-

(2) Disease is **one** of the following:

(a) Metastatic
(b) Advanced
(c) Recurrent

-AND-

(3) Cancer is positive for BRAF V600E mutation

-AND-

(4) Used in combination with Tafinlar (dabrafenib)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Mekinist** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Mekinist therapy

Authorization will be issued for 12 months.

D. Thyroid Cancer

1. **Initial Authorization**

a. **Mekinist** will be approved based on **one** of the following criteria:

(1) **All** of the following:

(a) Diagnosis of anaplastic thyroid cancer (ATC)

-AND-

(b) Cancer is positive for BRAF V600E mutation

-AND-

(c) Used in combination with Tafinlar (dabrafenib)

-AND-

(d) **One** of the following:

i. Disease is **one** of the following:

1. Metastatic
2. Locally advanced
3. Unresectable

-OR-

ii. Prescribed as adjuvant therapy following resection

-OR-

(2) **All** of the following:

(a) **One** of the following diagnoses:

i. Follicular Carcinoma
ii. Oncocytic Carcinoma
iii. Papillary Carcinoma

-AND-

(b) **One** of the following:

i. Unresectable locoregional recurrent disease
ii. Persistent disease
iii. Metastatic disease

-AND-

(c) **One** of the following:

i. Patient has symptomatic disease
ii. Patient has progressive disease

-AND-

(d) Disease is refractory to radioactive iodine treatment

-AND-

(e) Cancer is positive for BRAF V600 mutation

-AND-

(f) Used in combination with Tafinlar (dabrafenib)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Mekinist** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Mekinist therapy

Authorization will be issued for 12 months.

E. Central Nervous System (CNS) Cancers

1. **Initial Authorization**

a. **Mekinist** will be approved based on **all** of the following criteria:

(1) **One** of the following:

(a) Both of the following:

i. Patient has metastatic brain lesions

-AND-

ii. Mekinist is active against primary tumor (melanoma)

-OR-

(b) Patient has a glioma

-AND-

(2) Cancer is positive for BRAF V600E mutation

-AND-

(3) Used in combination with Tafinlar (dabrafenib)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Mekinist** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Mekinist therapy

Authorization will be issued for 12 months.

F. Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer

1. **Initial Authorization**

a. **Mekinist** will be approved based on **all** of the following criteria:

(1) Diagnosis of **one** of the following:

(a) Epithelial Ovarian Cancer
(b) Fallopian Tube Cancer
(c) Primary Peritoneal Cancer

-AND-

(2) **One** of the following:

(a) Persistent disease
(b) Recurrence in BRAF V600E positive tumors
(c) Recurrence of low-grade serous carcinoma

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Mekinist** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Mekinist therapy

Authorization will be issued for 12 months.

G. Hepatobiliary Cancers

1. **Initial Authorization**

a. **Mekinist** will be approved based on **all** of the following criteria:

(1) Diagnosis of **one** of the following:

(a) Gallbladder cancer
(b) Extrahepatic Cholangiocarcinoma
(c) Intrahepatic Cholangiocarcinoma

-AND-

(2) Used as subsequent treatment after progression on or after systemic treatment

-AND-

(3) Disease is unresectable or metastatic

-AND-

(4) Cancer is positive for BRAF V600E mutation

-AND-

(5) Used in combination with Tafinlar (dabrafenib)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Mekinist** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Mekinist therapy

Authorization will be issued for 12 months.

H. Histiocytic Neoplasms

1. **Initial Authorization**

a. **Mekinist** will be approved based on **both** of the following:

(1) Diagnosis of **one** of the following:

(a) Langerhans Cell Histiocytosis
(b) Erdheim-Chester Disease
(c) Rosai-Dorfman Disease

-AND-

(2) Mitogen-activated protein (MAP) kinase pathway mutation, no detectable mutation, or testing not available

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Mekinist** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Mekinist therapy

Authorization will be issued for 12 months.

I. Solid Tumors

1. **Initial Authorization**

a. **Mekinist** will be approved based on **all** of the following criteria:

(1) Presence of solid tumor

-AND-

(2) Used as subsequent treatment after progression on or after systemic treatment

-AND-

(3) Disease is unresectable or metastatic

-AND-

(4) Cancer is positive for BRAF V600E mutation

-AND-

(5) Used in combination with Tafinlar (dabrafenib)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Mekinist** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Mekinist therapy

Authorization will be issued for 12 months.

J. Pancreatic Cancer / Ampullary Cancer

1. **Initial Authorization**

a. **Mekinist** will be approved based on **all** of the following criteria:

(1) Diagnosis of **one** of the following:

(a) pancreatic adenocarcinoma
(b) ampullary adenocarcinoma

-AND-

(2) Disease is **one** of the following:

(a) Metastatic
(b) Locally advanced
(c) Unresectable

-AND-

(3) Cancer is positive for BRAF V600E mutation

-AND-

(4) Used in combination with Tafinlar (dabrafenib)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Mekinist** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Mekinist therapy

Authorization will be issued for 12 months.

K. Hairy Cell Leukemia

1. **Initial Authorization**

a. **Mekinist** will be approved based on **both** of the following:

(1) Diagnosis of hairy cell leukemia
(2) Used in combination with Tafinlar (dabrafenib)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Mekinist** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Mekinist therapy

Authorization will be issued for 12 months.

L. Salivary Gland Tumor

1. **Initial Authorization**

a. **Mekinist** will be approved based on **all** of the following criteria:

(1) Diagnosis of salivary gland tumor

-AND-

(2) Disease is **one** of the following:

(a) Recurrent and unresectable
(b) Metastatic

-AND-

(3) Cancer is positive for BRAF V600E mutation

-AND-

(4) Used in combination with Tafinlar (dabrafenib)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Mekinist** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Mekinist therapy

Authorization will be issued for 12 months.

M. Gastrointestinal Stromal Tumor (GIST)

1. **Initial Authorization**

a. **Mekinist** will be approved based on **all** the following criteria:

(1) Diagnosis of BRAF V600E-mutated GIST

-AND-

(2) Disease is **one** of the following:

(a) Gross residual disease (R2 resection)
(b) Unresectable primary disease
(c) Tumor rupture
(d) Progressive
(e) Recurrent
(f) Metastatic

-AND-

(3) Used in combination with Tafinlar (dabrafenib)

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Mekinist** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on **Mekinist** therapy

Authorization will be issued for 12 months.

N. NCCN Recommended Regimens

The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Mekinist [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2025.
2. The NCCN Drugs and Biologics Compendium (NCCN Compendium™). Available atwww.nccn.org. Accessed April 8, 2025.

Program	Prior Authorization/Notification - Mekinist (trametinib)
Change Control	
7/2013	New criteria for Mekinist which was approved 5/29/2013.
2/2014	Updated approval for combination therapy with Tafinlar.
5/2014	Auto-update to maintain on cycle review.
9/2014	Administrative change - Tried/Failed exemption for State of New Jersey removed.
5/2015	Updated coverage criteria and background with NCCN melanoma recommendation. Updated references. Increased authorization from 5

	months to 12 months.
5/2016	Annual review. Added coverage for NSCLC that has BRAF V600E mutation when used in combination with Tafinlar. Updated references.
3/2017	Annual review. Changed member to patient, with no change to coverage criteria. Updated reference.
3/2018	Annual review. Updated background information to include new indication in NSCLC with BRAF V600E mutation. Updated criteria to include NCCN recommendation of adjuvant treatment in combination with Tafinlar in stage III disease. Updated references.
3/2019	Annual review. Updated background information to include new indications for the adjuvant treatment of melanoma with BRAF V600 mutation. Updated background and criteria to include new indication and NCCN recommendation for the treatment of ATC with BRAF V600 mutations. Updated references.
3/2020	Annual review. Added general NCCN recommendations for use criteria. Updated references.
3/2021	Annual review. Added coverage criteria for NCCN recommendations for infiltrative supratentorial astrocytoma/oligodendroglioma, distant metastatic uveal melanoma, and epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer with persistent disease or recurrence of low-grade serous carcinoma. References updated.
3/2022	Annual review. Per NCCN recommendations updated CNS cancer criteria and added criteria for hepatobiliary cancer and histiocytic neoplasms. Updated background and references.
8/2022	Updated background and coverage criteria to include new indication for solid tumors with BRAF V600E mutation per package insert.
5/2023	Updated background and coverage criteria with indication for pediatric patients with low-grade glioma per prescribing information. Per NCCN recommendations: added coverage criteria for pancreatic cancer and ampullary cancer; updated coverage criteria for thyroid cancer, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, and CNS cancers. Updated references.
5/2024	Added coverage criteria for hairy cell leukemia, salivary gland tumor, and GIST per NCCN. Updated background and references.
5/2025	Annual review. Updated background and references.