Generic Name: N/A

Therapeutic Class or Brand Name: BRAF Inhibitor

Applicable Drugs (if Therapeutic Class): Braftovi (encorafenib)

Preferred: N/A

Non-preferred: N/A

Date of Origin: 1/9/2019

Date Last Reviewed: 10/21/2025

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through V are met)

I. Documented diagnosis of one of the following conditions A through C AND must meet criteria listed under applicable diagnosis:

FDA-Approved Indication(s)

A. Unresectable or metastatic melanoma
   1. Documentation of BRAF V600E or V600K mutations.
   2. Used in combination with Mektovi (binimetinib).

B. Metastatic colorectal cancer
   1. Documentation of BRAF V600E mutation AND either a or b
      a) Used in combination with Erbitux (cetuximab) and MFOLFOX6.
      b) Used in combination with Erbitux (cetuximab) after prior therapy.

C. Metastatic non-small cell lung cancer (NSCLC)
   1. Documentation of BRAF V600E mutation.
   2. Used in combination with Mektovi (binimetinib).

Other Uses With Supportive Evidence

A. BRAF V600 mutation positive cutaneous melanoma.
B. BRAF V600E mutation positive rectal cancer.
C. BRAF V600 mutation positive colon cancer.
D. BRAF V600 mutation positive appendiceal adenocarcinoma.
E. BRAF V600E mutation positive non-small cell lung cancer.

II. Minimum age requirement: 18 years old.

III. Treatment must be prescribed by or in consultation with an oncologist.

IV. Request is for a medication with the appropriate FDA labeling, or its use is supported by current clinical National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1 or 2A.

V. Refer to the plan document for the list of preferred products. If the requested agent is not listed as a preferred product, must have documented treatment failure or contraindication to the preferred product(s).

Exclusion Criteria

- Treatment of wild-type BRAF melanoma, wild-type BRAF CRC, or wild-type BRAF NSCLC.

Other Criteria

- N/A

Quantity / Days Supply Restrictions

- Melanoma: 180 capsules per 30 days.
- CRC/Appendiceal adenocarcinoma: 120 capsules per 30 days.
- NSCLC: 180 capsules per 30 days.

Approval Length

- **Authorization:** 6 months.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and does not show evidence of progressive disease.

Appendix

- N/A

References

1. Braftovi. Prescribing information. Pfizer Inc; March 2025. Accessed October 13, 2025. http://labeling.pfizer.com/ShowLabeling.aspx?id=12990 .
2. NCCN Clinical Practice Guidelines in Oncology. Melanoma: Cutaneous. V.2.2025. Updated January 28, 2025. Accessed October 14, 2025. https://www.nccn.org/professionals/physician_gls/pdf/cutaneous_melanoma.pdf .
3. NCCN Clinical Practice Guidelines in Oncology. Colon cancer. V.4.2025. Updated June 27, 2025. Accessed October 14, 20235. https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf

4. NCCN Clinical Practice Guidelines in Oncology. Rectal cancer. V.3.2025. Updated August 26, 2025. Accessed October 14, 2025. https://www.nccn.org/professionals/physician_gls/pdf/rectal.pdf
5. NCCN Clinical Practice Guidelines in Oncology. Non-small cell lung cancer. V.8.2025. Updated August 15, 2025. Accessed October 15, 2025. https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf