

Generic Name: N/A

Preferred: N/A

Therapeutic Class or Brand Name: MEK Inhibitor

Non-preferred: N/A

Applicable Drugs (if Therapeutic Class):

Date of Origin: 1/9/2019

Mektovi (Binimetinib)

Date Last Reviewed / Revised: 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 or B 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 Braftovi (encorafenib).
- B. Metastatic non-small cell lung cancer (NSCLC)
 1. Documentation of BRAF V600E mutation.
 2. Used in combination with Braftovi (encorafenib).

Other Uses With Supportive Evidence

- A. BRAF V600 mutation positive cutaneous melanoma.
- B. BRAF V600E mutation positive non-small cell lung cancer.
- C. Langerhans cell histiocytosis (if cobimetinib or trametinib are not tolerated).

- 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 or wild-type BRAF NSCLC.

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- 180 tablets 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. Mektovi. Prescribing information. Pflizer Inc; March 2025. Accessed October 14, 2025. <http://labeling.pfizer.com/ShowLabeling.aspx?id=12988>
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. 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
4. NCCN Clinical Practice Guidelines in Oncology. Histiocytic Neoplasms. V.1.2025. Updated June 20, 2025. https://www.nccn.org/professionals/physician_gls/pdf/histiocytic_neoplasms.pdf

DISCLAIMER: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgement in providing the most appropriate care for their patients.