

MEDICATION POLICY:**Avmapki Fakzynja Co-Pack (avutometinib / defactinib)**

Applicable Drugs: Avmapki Fakzynja
(avutometinib / defactinib)

Preferred: N/A

Non-preferred: N/A

Date of Origin: 9/8/2025

Date Last Reviewed / Revised: 7/23/2026

PRIOR AUTHORIZATION CRITERIA

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

- I. Documentation of the following FDA-approved diagnoses AND must meet all criteria listed under the applicable diagnosis:
FDA-Approved Indication(s)
 - A. Ovarian cancer
 - i. Documentation of low-grade serous ovarian cancer (LGSOC)
 - ii. Documentation of KRAS mutation
 - iii. Documentation of recurrent disease after prior systemic treatment, including a platinum-based regimen (ex. cisplatin or carboplatin)
 - iv. Avmapki Fakzynja will be used as monotherapy.
- II. Minimum age requirement: 18 years old or older
- III. Treatment must be prescribed by or in consultation with an oncologist or hematologist.
- 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

- N/A

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- Quantity limited to a 28-day supply

MEDICATION POLICY:

Avmapki Fakzynja Co-Pack (avutometinib / defactinib)



- Avmapki Fakzynja Co-Pack is supplied in a carton that contains:
 - Avmapki capsules (0.8 mg) in a 24-count bottle
 - Fakzynja tablets (200 mg) in a 42-count bottle
 - Dose: Avmapki 3.2 mg twice weekly (Day 1 and Day 4) and Fakzynja 200 mg twice daily, both taken for the first 3 weeks of each 4-week cycle

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. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology. Ovarian Cancer Including Fallopian Tube Cancer and Primary Peritoneal Cancer. Version 4.2026. Updated April 10, 2026. Accessed July 23, 2026. www.nccn.org/professionals/physician_gls/pdf/ovarian.pdf
2. Avmapki Fakzynja Co-Pack. Prescribing Information. Verastem, Inc. 2025. Accessed June 11, 2026. www.verastem.com/pdf/avmapki-fakzynja-co-pack-full-prescribing-information.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.