This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.

### Tafinlar (dabrafenib)

<table>
<thead>
<tr>
<th>Override(s)</th>
<th>Approval Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization</td>
<td>1 year</td>
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<tr>
<td>Quantity Limit</td>
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</table>

<table>
<thead>
<tr>
<th>Medications</th>
<th>Quantity Limit</th>
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</thead>
<tbody>
<tr>
<td>Tafinlar (dabrafenib)</td>
<td>May be subject to quantity limit</td>
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</tbody>
</table>

### APPROVAL CRITERIA

Requests for Tafinlar (dabrafenib) may be approved if the following criteria are met:

Individual has a diagnosis of one of the following:

I. Unresectable or metastatic melanoma:
   A. Individual is using in combination with trametinib for disease with BRAF V600E or V600K mutation with test results confirmed; OR
   B. Individual is using in combination with trametinib and has BRAF V600 activating mutation with test results confirmed; AND
      1. Using as first line subsequent therapy for disease progression (NCCN 1, 2A); OR
      2. Using in re-induction therapy with disease control, but experiences disease progression/relapse > 3 months after treatment discontinuation (NCCN 2A); OR
   C. Individual is using as monotherapy for disease with BRAF V600E mutation with test results confirmed;

   OR

II. Melanoma:
   A. Individual is using as adjuvant treatment; AND
   B. Individual is using in combination with trametinib; AND
   C. Individual has BRAF V600E or V600K mutations and test results confirmed; AND
   D. Individual has disease involvement of lymph node(s), following complete resection or wide excision;

   OR

III. Locally advanced or metastatic anaplastic thyroid cancer (ATC):
   A. Individual is using in combination with trametinib; AND
   B. Individual has BRAF V600E mutation and test results confirmed; AND
This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.
Market Applicability

<table>
<thead>
<tr>
<th>Market</th>
<th>GA</th>
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<th>MD</th>
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<tbody>
<tr>
<td>Applicable</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</table>

5. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2020; Updated periodically.

Federal and state laws or requirements, contract language, and Plan utilization management programs or polices may take precedence over the application of this clinical criteria.

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