PRIOR AUTHORIZATION POLICY

POLICY: Oncology – Avmapki Fakzynja Co-Pack Prior Authorization Policy
- Avmapki™ Fakzynja™ Co-Pack (avutometinib capsules; defactinib tablets co-packaged – Verastem)

REVIEW DATE: 05/14/2025; selected revision 06/04/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Avmapki Fakzynja Co-Pack, a co-packaged product of two kinase inhibitors, is indicated for the treatment of Kirsten RAt Sarcoma (*KRAS)*-mutated recurrent low-grade serous ovarian cancer in adults who have received prior systemic therapy.[1]

This indication is approved under accelerated approval based on tumor 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.

Guidelines

Avmapki Fakzynja Co-Pack is addressed in the National Comprehensive Cancer Network (NCCN) Ovarian Cancer Including Fallopian Tube Cancer and Primary Peritoneal Cancer guidelines (version 2.2025 – May 23, 2025). The following recurrence targeted therapies are recommended for epithelial ovarian (including less

common ovarian cancers)/fallopian tube/primary peritoneal cancer as "Useful in Certain Circumstances" for both platinum-sensitive or platinum-resistant disease: Avmapki Fakzynja Co-Pack for low grade serous carcinoma for *KRAS*-mutated tumors (category 2A); Mekinist® (trametinib tablets and oral solution) [category 2A]; and Mektovi® (binimetinib tablets) [category 2B]. Primary "preferred" regimens for low-grade serous (stage IC) cancer include paclitaxel/carboplatin ± maintenance letrozole or other hormonal therapy (category 2B) or hormone therapy (aromatase inhibitors [AI]: anastrozole, letrozole, or exemestane) [category 2B].[2] Primary "preferred" regimens for low-grade serous ovarian cancer (stage II – stage IV disease) includes paclitaxel/carboplatin/bevacizumab + maintenance bevacizumab (category 2A); paclitaxel/carboplatin ± maintenance letrozole (category 2B) or other hormonal therapy (category 2B); or hormone therapy (AI: anastrozole, letrozole, or exemestane) [category 2B].

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Avmapki Fakzynja Co-Pack. All approvals are provided for the duration noted below.

- **Avmapki™ Fakzynja™ Co-Pack (avutometinib capsules; defactinib tablets co-packaged – Verastem)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Ovarian, Fallopian Tube, or Primary Peritoneal Cancer.** Approve for 1 year if the patient meets ALL of the following (A, B, C and D):
   - **A)** Patient is ≥ 18 years of age; AND
   - **B)** Patient has recurrent low-grade serous cancer; AND
   - **C)** The cancer has a *KRAS* mutation; AND
   - **D)** Patient has tried at least one systemic therapy.
     Note: Examples of systemic therapy include one or more of the following medications: paclitaxel, carboplatin, bevacizumab, letrozole, anastrozole, or exemestane.

CONDITIONS NOT COVERED

- **Avmapki™ Fakzynja™ Co-Pack (avutometinib capsules; defactinib tablets co-packaged – Verastem)**

is(are) considered not medically necessary for ANY other use(s); criteria will be updated as new published data are available.

REFERENCES

1. Avmapki™ Fakzynja™ Co-Pack [prescribing information]. Needham, MA: Verastem; May 2025.
2. The NCCN Ovarian Cancer Including Fallopian Tube Cancer and Primary Peritoneal Cancer Clinical Practice Guidelines in Oncology (version 1.2025 – May 23, 2025). © 2025 National Comprehensive Cancer Network. Available at: http://www.nccn.org. Accessed on May 29, 2025.

HISTORY

Type of Revision	Summary of Changes	Review Date
New Policy	--	05/14/2025
Selected Revision	**Ovarian, Fallopian Tube, or Primary Peritoneal Cancer**: This condition of approval was previously worded as "ovarian cancer." The word "ovarian" was removed from the requirement that the patient has recurrent low-grade cancer.	06/04/2025