Clinical Policy: Tovorafenib (Ojemda)

Reference Number: CP.PHAR.686
Effective Date: 09.10.24
Last Review Date: 08.24
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Tovorafenib (Ojemda™) is a kinase inhibitor.

FDA Approved Indication(s)

Ojemda is indicated for the treatment of pediatric patients 6 months of age and older with relapsed or refractory pediatric low-grade glioma (LGG) harboring a BRAF fusion or rearrangement, or BRAF V600 mutation.*

**This indication is approved under accelerated approval based on 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(s).*

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Ojemda is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Pediatric Low-Grade Glioma (must meet all)**:**

1. Diagnosis of relapsed or refractory LGG;
2. Prescribed by or in consultation with an oncologist;
3. Age ≥ 6 months;
4. Disease is positive for one of the following (a or b):
   a. BRAF fusion or rearrangement;
   b. BRAF V600 mutation;
5. Failure of at least one line of prior systemic therapy (*see Appendix B for examples*);
6. Documentation of the member's current body surface area (BSA)(m^2);
7. Request meets one of the following (a or b):*
   a. Dose does not exceed both of the following (i and ii):
      i. 380 mg per m^2 of BSA;
      ii. 600 mg once weekly;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Pediatric Low-Grade Glioma (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Ojemda for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, request meets one of the following (a or b):*
   a. Both of the following (i and ii):
      i. Documentation of the member's current body surface area (BSA)(m^2);
      ii. Dose does not exceed both of the following (1 and 2):
         1) 380 mg per m^2 of BSA;
         2) 600 mg once weekly;
   b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).

**Prescribed regimen must be FDA-approved or recommended by NCCN*

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

BRAF: B-Raf proto-oncogene, serine/threonine kinase
BSA: body surface area
FDA: Food and Drug Administration
LGG: low grade glioma
WHO: World Health Organization

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
vincristine†/ carboplatin†	Ages > 3 months to ≤ 16 years *Induction Therapy* vincristine 1.5 mg/m^2 IV continuous infusion once weekly; carboplatin 175 mg/m^2 IV continuous infusion once weekly on weeks 1 - 4 and 7 - 10. *Maintenance Therapy* vincristine 1.5 mg/m^2 IV continuous infusion once weekly for 3 weeks; carboplatin 175 mg/m^2 IV continuous infusion once weekly for 4 weeks; repeat every 6 weeks for 8 cycles.	See dosing regimen
vinblastine†	vinblastine 6 mg/m^2 IV continuous infusion once weekly until disease progression or unacceptable toxicity	See dosing regimen

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
†Off-label

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information
An FDA approved test for the detection of BRAF fusion or rearrangement, or BRAF V600 mutation in relapsed or refractory pediatric LGG is not currently available. However, independent labs offer testing for BRAF mutations and BRAF rearrangements. BRAF mutation tests are conducted through gene sequencing while BRAF rearrangements are detected through testing by FISH, fluorescence in situ hybridization. The University of San Francisco's Health Center for Clinical Genetics and Genomics offers both tests to external physicians.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Pediatric LGG	Recommended dosage of Ojemda based on BSA: 380 mg/m^2 Tablets: • 0.30 to 0.89 m^2: Administer Ojemda oral suspension once weekly • 0.90 to 1.12 m^2: 400mg PO once weekly • 1.13 to 1.39 m^2: 500mg PO once weekly • ≥1.40 m^2: 600mg PO once weekly Oral Suspension: • 0.30 to 0.35 m^2: 125 mg (5 mL) PO once weekly • 0.36 to 0.42 m^2: 150 mg (6 mL) PO once weekly • 0.43 to 0.48 m^2: 175 mg (7 mL) PO once weekly • 0.49 to 0.54 m^2: 200 mg (8 mL) PO once weekly • 0.55 to 0.63 m^2: 225 mg (9 mL) PO once weekly • 0.64 to 0.77 m^2: 275 mg (11 mL) PO once weekly • 0.78 to 0.83 m^2: 300 mg (12 mL) PO once weekly • 0.84 to 0.89 m^2: 350 mg (14 mL) PO once weekly • 0.90 to 1.05 m^2: 375 mg (15 mL) PO once weekly • 1.06 to 1.25 m^2: 450 mg (18 mL) PO once weekly • 1.26 to 1.39 m^2: 525 mg (21 mL) PO once weekly • ≥1.40 m^2: 600 mg (24 mL) PO once weekly The recommended duration of treatment is until disease progression or unacceptable toxicity.	600 mg/week

VI. Product Availability

- Tablets: 100 mg
- Oral suspension: 300 mg/12 mL

VII. References

1. Ojemda Prescribing Information. Brisbane, CA: Day Biopharmaceuticals, Inc.; April 2024. Available at: https://www.ojemda.com/ Accessed May 13, 2024.
2. Ater JL, Zhou T, Holmes E, et al. Randomized study of two chemotherapy regimens for treatment of low-grade glioma in young children: a report from the Children's Oncology Group. J Clin Oncol. 2012;30(21):2641-7.
3. Bouffet E, Jakacki R, Goldman S, et al. Phase II study of weekly vinblastine in recurrent or refractory pediatric low-grade glioma. J Clin Oncol. 2012;30(12):1358-63.
4. BRAF Mutation Testing (including V600E). UCSF Health Center for Clinical Genetics and Genomics. Available at: https://genomics.ucsf.edu/content/braf-mutation-testing-including-v600e. Accessed May 27, 2024
5. BRAF Rearrangement by FISH. UCSF Health Center for Clinical Genetics and Genomics. Available at: https://genomics.ucsf.edu/content/braf-rearrangement-fish. Accessed May 27, 2024.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	06.20.24	08.24

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan

retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.