Evolent Clinical Guideline 3082 for Tafinlar™ (dabrafenib)

Guideline Number: Evolent_CG_3082	**Applicable Codes**	
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STATEMENT

Purpose

To define and describe the accepted indications for Tafinlar (dabrafenib) usage in the treatment of cancer, including FDA approved indications, and off-label indications.

Evolent is responsible for processing all medication requests from network ordering providers. Medications not authorized by Evolent may be deemed as not approvable and therefore not reimbursable.

The use of this drug must be supported by one of the following: FDA approved product labeling, CMS-approved compendia, National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO) clinical guidelines, or peer-reviewed literature that meets the requirements of the CMS Medicare Benefit Policy Manual Chapter 15.

INDICATIONS

Continuation requests for a not-approvable medication shall be exempt from this Evolent policy provided

- The member has not experienced disease progression on the requested medication AND
- The requested medication was used within the last year without a lapse of more than 30 days of having an active authorization AND
- Additional medication(s) are not being added to the continuation request.

Low Grade Glioma

- Tafinlar (dabrafenib) may be used in combination with Mekinist (trametinib) in members 1 year of age and older with low grade glioma with a BRAF V600E mutation.

Malignant Melanoma

- Tafinlar (dabrafenib) may be used in combination with Mekinist (trametinib) as adjuvant treatment, following complete resection, for melanoma with BRAF V600E or V600K mutations OR
- Tafinlar (dabrafenib) may be used in combination with Mekinist (trametinib) in members with unresectable or metastatic BRAF V600E or V600K mutation positive melanoma.

Non-Small Cell Lung Cancer (NSCLC)

- Tafinlar (dabrafenib) may be used in combination with Mekinist (trametinib) as first line or subsequent line therapy for recurrent or metastatic BRAF V600E mutation-positive NSCLC, if anti-BRAF targeted therapy was not previously used.

Solid Tumors with BRAF V600E mutation (excluding colorectal cancer)

- Tafinlar (dabrafenib) may be used in combination with Mekinist (trametinib) in adult or pediatric members greater than or equal to 1 year of age with unresectable or metastatic solid tumors with BRAF V600E mutation, as subsequent therapy.

Thyroid Carcinoma

- The member has anaplastic, papillary, follicular, and Hürthle Cell thyroid carcinoma and Tafinlar (dabrafenib) may be used in combination with Mekinist (trametinib) for radioactive iodine-refractory (if radioactive iodine therapy is appropriate) BRAF V600E mutation positive unresectable/recurrent/metastatic disease

CONTRAINDICATIONS/WARNINGS

- None

EXCLUSION CRITERIA

- The member has wild-type BRAF tumors.
- Disease progression while taking any MEK inhibitor + BRAF inhibitor combination.
- Dosing exceeds single dose limit of Tafinlar (dabrafenib) 150 mg.
- Treatment exceeds the maximum limit of 120 (50 mg) or 120 (75 mg) capsules/month, or 840 (10 mg) tablets for oral suspension/month.
- Treatment exceeds the maximum 12 months duration limit when used as adjuvant melanoma treatment following complete resection of the primary lesion and completion of a regional lymph node dissection.
- Investigational use of Tafinlar (dabrafenib) with an off-label indication that is not sufficient in evidence or is not generally accepted by the medical community. Sufficient evidence that is not supported by CMS recognized compendia or acceptable peer reviewed literature is defined as any of the following:
    - Whether the clinical characteristics of the patient and the cancer are adequately represented in the published evidence.
    - Whether the administered chemotherapy/biologic therapy/immune therapy/targeted therapy/other oncologic therapy regimen is adequately represented in the published evidence.
    - Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients. Generally, the definitions of Clinically Meaningful outcomes are those recommended by ASCO, e.g., Hazard Ratio of less than 0.80 and the recommended survival benefit for OS and PFS should be at least 3 months.

- Whether the experimental design, considering the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover).
- That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs.
- That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
- That abstracts (including meeting abstracts) without the full article from the approved peer-reviewed journals lack supporting clinical evidence for determining accepted uses of drugs.

CODING AND STANDARDS

Codes

- J8999 - dabrafenib

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☒	Commercial
☒	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

POLICY HISTORY

Date	Summary
May 2026	• Added tablet formulation details to exclusion criteria • Updated references
May 2025	• Converted to new Evolent guideline template • This guideline replaces UM ONC_1250 Tafinlar (dabrafenib) • Updated maximum dosage form quantities in exclusion criteria • Updated exclusion criteria • Updated references
May 2024	• Updated solid tumor indication section to include use in pediatric members ≥ 1 year of age • Added new references • Updated NCH verbiage to Evolent

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Specialty Services Clinical Guideline Review Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

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