AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Ojemda	Page:	1 of 2
Effective Date:	10/25/2024	Last Review Date:	6/13/2024

Applies to:	☒Illinois	☒New Jersey	☒Virginia
	☒Maryland	☒Florida Kids	☒Pennsylvania Kids

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Ojemda under the patient's prescription drug benefit.

Description:

FDA-Approved Indication

Treatment of 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.

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Ojemda

Policy/Guideline:

I. Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- Medical record documentation of activating BRAF alteration

II. Criteria for Initial Approval:

Central Nervous System Cancer

Authorization may be granted when the following criteria are met:

- Request is for treatment of members 6 months of age and older
- Member has relapsed or refractory pediatric low-grade glioma harboring a BRAF fusion or rearrangement, or BRAF V600 mutation

III. Criteria for Continuation of Therapy

Central Nervous System Cancer

Authorization may be granted for continued treatment when the following criteria are met:

- Member is requesting reauthorization for the indication of Central Nervous System Cancer
- Member has no evidence of unacceptable toxicity or disease progression while on the current regimen

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 12 months

Quantity Level Limit: Maximum dose is 600mg once weekly.

References:

1. Ojemda [package insert]. Brisbane, CA: Day One Biopharmaceuticals, Inc.; April 2024.