

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1476-1
Program	Prior Authorization/Notification
Medication	Gomekli™ (mirdametinib)
P&T Approval Date	4/2025
Effective Date	7/1/2025

1. Background:

Gomekli is a kinase inhibitor indicated for the treatment of adult and pediatric patients 2 years of age and older with neurofibromatosis type 1 (NF1) who have symptomatic plexiform neurofibromas (PN) not amenable to complete resection.

Coverage Information:

Members will be required to meet the criteria below for coverage. For members under the age of 19 years, the prescription will automatically process without a coverage review.

Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances. Some states also mandate usage of other Compendium references. Where such mandates apply, they supersede language in the benefit document or in the notification criteria.

2. Coverage Criteria^a:**A. Patients less than 19 years of age****1. Gomekli** will be approved based on the following criterion:

- a. Patient is less than 19 years of age

Authorization will be issued for 12 months.

B. Neurofibromatosis Type 1**1. Initial Authorization**

- a. **Gomekli** will be based approved based on **both** of the following:

- (1) Diagnosis of neurofibromatosis type 1

-AND-

- (2) Patient has plexiform neurofibromas (PN) that are **both** of the following:

- (a) Symptomatic
- (b) Not amenable to complete resection

Authorization will be issued for 12 months.

1. **Reauthorization**

a. **Gomekli** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Gomekli therapy.

Authorization will be issued for 12 months.

C. NCCN Recommended Regimens

The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Authorization will be issued for 12 months.

^a State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

- Gomekli™ [package insert]. Stamford, CT: SpringWorks Therapeutics, Inc; February, 2025.

Program	Prior Authorization/Notification - Gomekli™ (mirdametinib)
Change Control	
4/2025	New program.