RxAdvance

Clinical Policy Title:	adagrasib
Policy Number:	RxA.790
Drug(s) Applied:	Krazati™
Original Policy Date:	4/13/2023
Last Review Date:	12/11/2025
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Non-Small Cell Lung Cancer (must meet all)**:**

1. Diagnosis of locally advanced or metastatic non-small cell lung cancer;
2. Prescribed as a single agent;
3. Disease is positive for KRAS G12C mutation;
4. Member has received at least one prior systemic therapy.

B. Colorectal Cancer (must meet all):

1. Diagnosis of locally advanced or metastatic colorectal cancer;
2. Prescribed in combination with cetuximab;
3. Disease is positive for KRAS G12C mutation;
4. Member has received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy.

Approval Duration
All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. Non-Small Cell Lung Cancer (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

Approval Duration
All Lines of Business (except Medicare): 12 months

References

1. National Comprehensive Cancer Network Guidelines. Non-Small Cell Lung Cancer. Version 3.2025. Available at: https://www.nccn.org/professionals/physician_gls/pdf/nscl.pdf. Accessed March 24, 2025.
2. Krazati. Package insert. Mirati Therapeutics. 2024. Available at: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=0b8bf078-34c2-4f45-9012-38a8ac082b01&type=display. Accessed March 24, 2025.

Review/Revision History	Review/Revision Date	P&T Approval Date

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

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Policy established.	03/16/2023	04/13/2023
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed. 1. Removed reathorization requirement for positive response to therapy. 2. Removed age requirement. 3. Removed restriction for previous treatment with Lumakras. 4. References were reviewed and updated. 5. Removed prescriber restriction 6. Removed dose restriction	4/15/2024	
Policy was reviewed: 1. Updated continuation of therapy language.	03/24/2025	04/10/2025
Policy reviewed.	12/11/2025	12/11/2025

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