



AETNA BETTER HEALTH®  
Coverage Policy/Guideline

Name: Ojemda

Page: 1 of 2

Effective Date: 8/27/2026

Last Review Date: 7/2026

|             |                                                       |                                              |                                                  |
|-------------|-------------------------------------------------------|----------------------------------------------|--------------------------------------------------|
| Applies to: | <input checked="" type="checkbox"/> Illinois          | <input type="checkbox"/> Florida             | <input type="checkbox"/> Michigan                |
|             | <input checked="" type="checkbox"/> New Jersey        | <input checked="" type="checkbox"/> Maryland | <input checked="" type="checkbox"/> Florida Kids |
|             | <input checked="" type="checkbox"/> Pennsylvania Kids | <input checked="" type="checkbox"/> Virginia | <input type="checkbox"/> Kentucky PRMD           |

**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 Indications<sup>1</sup>

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.

Compendial Uses<sup>2</sup>

- Central Nervous System (CNS) Cancers
  - Circumscribed glioma – WHO grade 1 or 2
  - Pleomorphic xanthoastrocytoma – WHO grade 2
- Langerhans Cell Histiocytosis (LCH)

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

**Applicable Drug List:**

Ojemda

**Policy/Guideline:**

**Documentation**

Submission of the following information is necessary to initiate the prior authorization review: medical record documentation of activating BRAF alteration.

**Coverage Criteria**

Central Nervous System (CNS) Cancers<sup>1,2</sup>

Authorization of 12 months may be granted for treatment of CNS cancers harboring a BRAF fusion or rearrangement, or BRAF V600 mutation, as a single agent, when either of the following criteria are met:

- Member is 6 months of age and older with relapsed or refractory pediatric low-grade glioma



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- Member has recurrent or progressive, WHO grade 1 or 2 circumscribed glioma or WHO grade 2 pleomorphic xanthoastrocytoma

Langerhans Cell Histiocytosis (LCH)<sup>2</sup>

- Authorization of 12 months may be granted for treatment of LCH with BRAF alterations, as a single agent.

**Continuation of Therapy**

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication in the Coverage Criteria section when there is 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:**

- Box of 4 blister cards: 1 box per 28 days
- 25 mg/mL bottle for oral suspension: 8 bottles per 28 days

**References:**

- Ojemda [package insert]. Brisbane, CA: Day One Biopharmaceuticals, Inc.; August 2025.
- The NCCN Drugs & Biologics Compendium® © 2026 National Comprehensive Cancer Network, Inc. Available at: <https://www.nccn.org>. Accessed May 11, 2026.