Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

CVS caremark™ {{PANUMCODE}}

Braftovi

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the patient's diagnosis?
   - ❑ Cutaneous melanoma
   - ❑ Glioma
   - ❑ Meningioma
   - ❑ Astrocytoma
   - ❑ Colorectal cancer
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this a request for continuation of therapy with the requested drug?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*
4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Cutaneous Melanoma

5. Will the requested medication be used in combination with binimetinib (Mektovi)? ❑ Yes ❑ No
6. Does the patient have BRAF V600E or V600K mutations? ***ACTION REQUIRED: Please attach documentation of BRAF V600 mutation status.*** ❑ Yes ❑ No
7. In which of the following settings will the medication be used?
   - ❑ Unresectable or metastic disease, *no further questions*
   - ❑ Adjuvant therapy
   - ❑ Other _____
8. Does the patient have stage III disease? ❑ Yes ❑ No
9. Has the patient had a complete resection? *If Yes, skip to #11* ❑ Yes ❑ No
10. Does the patient have evidence of disease? ❑ Yes ❑ No

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11. Has the patient had an unacceptable toxicity to therapy with dabrafenib (Tafinlar) in combination with trametinib (Mekinist)? ❑ Yes ❑ No

Section B: Glioma, Meningioma, and Astrocytoma

12. What is the patient's BRAF V600 mutation status (e.g., BRAF V600E or V600K)? ***ACTION REQUIRED: Please attach documentation of BRAF V600 mutation status.*** ❑ Positive ❑ Negative ❑ Unknown or not available

Section C: Colorectal Cancer

13. Will the requested medication be used in combination with either Erbitux or panitumumab (Vectibix)? ❑ Yes ❑ No

14. What is the patient's BRAF V600E mutation status? ***ACTION REQUIRED: Please attach documentation of BRAF V600E mutation status.*** ❑ Positive ❑ Negative ❑ Unknown or not available

15. Will the requested medication be used as subsequent therapy for advanced or metastatic disease? *If Yes, no further questions* ❑ Yes ❑ No

16. Will the requested medication be used as primary treatment for unresectable metachronous metastases and has had previous adjuvant FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin) within the past 12 months? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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