CareFirst
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

Mekinist

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-866-249-6155

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.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

1. What is the patient's diagnosis?
   ❑ Melanoma
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the disease unresectable or metastatic? ❑ Yes ❑ No
4. Has genetic testing been performed for the BRAF V600E or V600K mutation? ❑ Yes ❑ No
   ACTION REQUIRED: Attach test results
5. What was the member's BRAF mutation test result? ❑ Positive ❑ Negative
6. Will Mekinist be used in combination with Tafinlar (dabrafenib)? *If Yes, no further questions.* ❑ Yes ❑ No
7. Will Mekinist be used as a single agent? ❑ Yes ❑ No
8. Is the member's anticipated clinical deterioration less than or equal to 12 weeks? ❑ Yes ❑ No
9. Has the member experienced intolerance to previous BRAF-inhibitor therapy (eg, vemurafenib [Zelboraf], dabrafenib [Tafinlar])? ❑ 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)**