

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



[[PANUMCODE]]

## Mektovi

### 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.

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**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}}

- What is the patient's diagnosis?  
 Cutaneous melanoma  Glioma  
 Meningioma  Astrocytoma  
 Other \_\_\_\_\_
- What is the ICD-10 code? \_\_\_\_\_
- Is this a request for continuation of therapy with the requested drug?  
 Yes  No *If No, skip to diagnosis section*
- 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

- Will the requested medication be used in combination with Braftovi (encorafenib)?  Yes  No
- Does the patient have BRAF V600E or V600K mutations? **ACTION REQUIRED: Please attach documentation of BRAF V600 mutation status.**  Yes  No  Unknown or not available
- In which of the following settings will the medication be used?  
 Unresectable or metastatic disease, *no further questions*  
 Adjuvant therapy  
 Other \_\_\_\_\_
- Does the patient have stage III disease?  Yes  No
- Has the patient had a complete resection? *If Yes, skip to #11*  Yes  No
- Does the patient have evidence of disease?  Yes  No
- Has the patient had an unacceptable toxicity to therapy with dabrafenib (Tafinlar) in combination with trametinib (Mekinist)?  Yes  No

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155**

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Section B: Glioma, Meningioma, 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

*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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