

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



{{PANUMCODE}}

Tafinlar

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?
 - Melanoma BRAF V600 activating mutation-positive
 - Non-small cell lung cancer, BRAF V600E mutation-positive
 - Anaplastic thyroid cancer (ATC), BRAF V600E mutation-positive
 - Glioma, BRAF V600 mutation-positive
 - Meningioma, BRAF V600 mutation-positive
 - Astrocytoma, BRAF V600 mutation-positive
 - Follicular thyroid carcinoma, BRAF mutation positive
 - Hurthle cell thyroid carcinoma, BRAF mutation positive
 - Papillary thyroid carcinoma, BRAF mutation positive
 - Hepatobiliary cancers (gallbladder cancer, extrahepatic cholangiocarcinoma, intrahepatic cholangiocarcinoma)
 - Histiocytic neoplasms
 - Treatment of cutaneous melanoma
 - Solid tumors, BRAF V600E mutation-positive
 - Other _____

- What is the ICD-10 code? _____

Complete the following questions if the diagnosis is cutaneous melanoma. If diagnosis is NOT cutaneous melanoma, please skip to #8.

- The preferred products for your patient's health plan are: Braftovi, Cotellic, Mektovi, and Zelboraf. Can the patient's treatment be switched to a preferred product? **If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.**
 - Yes - Braftovi Yes - Cotellic
 - Yes - Mektovi Yes - Zelboraf
 - No - Continue request for non-preferred product, Tafinlar
- Is this a request for continuation of therapy with the requested drug? Yes No *If No, skip to #6*

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

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5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. Yes No *If No, skip to #8*
6. Is the requested product being used for adjuvant treatment? *If Yes, skip to #8* Yes No
7. Does the patient have a documented inadequate response or intolerable adverse event to ANY of the preferred products? *Indicate ALL that apply. ACTION REQUIRED: If Yes, attach supporting chart note(s).*

<input type="checkbox"/> Yes - Braftovi	<input type="checkbox"/> Inadequate response	<input type="checkbox"/> Intolerable adverse event
<input type="checkbox"/> Yes - Cotellic	<input type="checkbox"/> Inadequate response	<input type="checkbox"/> Intolerable adverse event
<input type="checkbox"/> Yes - Mektovi	<input type="checkbox"/> Inadequate response	<input type="checkbox"/> Intolerable adverse event
<input type="checkbox"/> Yes - Zelboraf	<input type="checkbox"/> Inadequate response	<input type="checkbox"/> Intolerable adverse event
<input type="checkbox"/> No - None of the above		
8. Is this a request for continuation of therapy with the requested drug? Yes No *If No, skip to #12*
9. Is there evidence of unacceptable toxicity or disease progression or recurrence while on the current regimen? Yes No
10. Is this request for the adjuvant treatment of cutaneous melanoma? Yes No *If No, no further questions.*
11. How many months of therapy has the patient received? _____ months *No further questions.*
12. What is the patient's mutation status? **ACTION REQUIRED: Please attach documentation of mutation status.**

<input type="checkbox"/> BRAF V600 positive
<input type="checkbox"/> BRAF V600 negative
<input type="checkbox"/> BRAF V600E positive
<input type="checkbox"/> BRAF V600E negative
<input type="checkbox"/> Unknown or not available
13. How will the requested medication be given? *Indicate ALL that apply.*

<input type="checkbox"/> As a single agent
<input type="checkbox"/> In combination with Mekinist (trametinib)
<input type="checkbox"/> None of the above

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

Section A: Melanoma

14. In what setting will the requested medication be used?

<input type="checkbox"/> Adjuvant treatment of cutaneous melanoma
<input type="checkbox"/> Treatment of unresectable cutaneous melanoma, <i>no further questions.</i>
<input type="checkbox"/> Treatment of metastatic cutaneous melanoma, <i>no further questions.</i>
<input type="checkbox"/> Treatment of brain metastases from melanoma, <i>no further questions.</i>
<input type="checkbox"/> None of the above
15. Does the patient have stage III disease? Yes No
16. Has the patient had a complete resection? *If Yes, no further questions.* Yes No
17. Does the patient have evidence of disease? Yes No

Section B: Non-Small Cell Lung Cancer

18. Does the patient have recurrent, advanced, or metastatic disease? Yes No

Section C: Anaplastic Thyroid Cancer

19. Is the disease locally advanced or metastatic? Yes No

Section D: Thyroid Carcinoma

20. Is the disease progressive and/or symptomatic? Yes No
21. Is the thyroid carcinoma not amendable to radioiodine (RAI) therapy? Yes No

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Section E: Hepatobiliary Cancers (Gallbladder Cancer, Extrahepatic Cholangiocarcinoma, Intrahepatic Cholangiocarcinoma)

22. In which line of therapy will the requested medication be used?

- First line therapy
 Subsequent therapy

23. Will the requested medication be used for progressive unresectable or metastatic disease? Yes No

Section F: Histiocytic Neoplasms

24. Will the requested medication be used for treatment of Erdheim-Chester disease or Langerhans cell histiocytosis?

- Yes No

Section G :Solid Tumors, BRAF V600E Mutation Positive

25. Will the requested medication be used for unresectable or metastatic solid tumors? Yes No

26. Has the disease progressed following prior treatment? Yes No

27. Are there satisfactory alternative treatment options available? Yes No

28. Will the requested medication be used for the treatment of colorectal cancer? 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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