

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
 - 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 #7*
- Is there evidence of unacceptable toxicity or disease progression on the current regimen? Yes No
- Is this request for the adjuvant treatment of cutaneous melanoma? Yes No *If No, no further questions*
- How many months of therapy has the patient received? _____ months *No further questions*
- What is the patient's mutation status? **ACTION REQUIRED: Please attach documentation of mutation status.**
 - BRAF V6000 positive BRAF V6000 negative
 - BRAF V600E positive BRAF V600E negative
 - Unknown or not available
- How will the requested medication be given? **Indicate ALL that apply.**
 - As a single agent
 - As subsequent therapy
 - In combination with Mekinist (trametinib)
 - In combination with Mekinist (trametinib) and either cetuximab or panitumumab
 - None of the above

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

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

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

Section A: Melanoma

9. In what setting will the requested medication be used?
- Adjuvant treatment of cutaneous melanoma
 - Treatment of unresectable cutaneous melanoma, *no further questions*
 - Treatment of metastatic cutaneous melanoma, *no further questions*
 - Treatment of brain metastases from melanoma, *no further questions*
 - None of the above
10. Does the patient have stage III disease? Yes No
11. Has the patient had a complete resection? *If Yes, no further questions* Yes No
12. Does the patient have evidence of disease? Yes No

Section B: Non-Small Cell Lung Cancer

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

Section C: Thyroid Carcinoma

14. Is the disease progressive and/or symptomatic? Yes No
15. Is the disease iodine-refractory? 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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