CVS caremark™ {{PANUMCODE}}

Zelboraf

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
   - ❑ Non-small cell lung cancer
   - ❑ Hairy cell leukemia
   - ❑ Erdheim-Chester disease
   - ❑ Thyroid carcinoma (papillary, follicular, Hurthle cell)
   - ❑ Glioma
   - ❑ Meningioma
   - ❑ Astrocytoma
   - ❑ 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 #5*

4. Is there evidence of unacceptable toxicity or disease progression on the current regimen?
   ❑ Yes ❑ No *No further questions*

5. Is the disease:
   - ❑ BRAF V600 mutation-positive
   - ❑ BRAF V600E mutation-positive
   - ❑ BRAF V600E mutation-negative
   - ❑ BRAF mutation-positive
   - ❑ BRAF V600K mutation-positive
   - ❑ BRAF V600K mutation-negative

   ACTION REQUIRED: Please attach documentation of BRAF mutation status.
   - ❑ Unknown or not available

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

Section A: Cutaneous Melanoma

6. In which of the following settings will the requested medication be used?
   - ❑ Unresectable or metastatic disease, *skip to #12*
   - ❑ Adjuvant treatment
   - ❑ Other

7. Does the patient have stage III disease? ❑ Yes ❑ No

8. Has the patient had a complete resection? *If Yes, skip to #10* ❑ Yes ❑ No

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9. Does the patient have evidence of disease? ❑ Yes ❑ No

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

11. Will the requested medication be used in combination with cobimetinib (Cotellic)?
    ❑ Yes ❑ No *No further questions*

12. In what regimen will the requested medication be used?
    ❑ In combination with cobimetinib (Cotellic) only
    ❑ In combination with cobimetinib (Cotellic) and atezolizumab (Tecentriq)
    ❑ As a single agent
    ❑ Other _____

Section B: Non-Small Cell Lung Cancer

13. Is the disease recurrent, advanced, or metastatic? ❑ Yes ❑ No

Section C: Thyroid Carcinoma

14. Is the thyroid carcinoma not amendable to radioiodine (RAI) therapy? ❑ Yes ❑ No

Section D: Hairy Cell Leukemia

15. Is the requested medication used as a single agent or in combination with rituximab? ❑ Yes ❑ No

16. What is the place in therapy in which the requested drug will be used?
    ❑ First line therapy ❑ Subsequent

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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