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

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
   - ❑ Colorectal cancer
   - ❑ 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. Is the disease unresectable or metastatic? ❑ Yes ❑ No

7. Which of the following regimens will the requested drug be used?
   - ❑ Zelboraf will be used as a single agent
   - ❑ Zelboraf will be used in combination with cobimetinib (Cotellic) only
   - ❑ Zelboraf will be used in combination with cobimetinib (Cotellic) and atezolizumab (Tecentriq)
   - ❑ Other _____

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

Section B: Non-small Cell Lung Cancer

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

Section C: Thyroid Carcinoma

9. Is the thyroid carcinoma radioiodine refractory? ❑ Yes ❑ No

Section D: Hairy Cell Leukemia

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

11. What is the place in therapy in which the requested drug will be used?
    ❑ Subsequent ❑ Other _____

Section E: Colorectal Cancer

12. Is the requested drug used in combination with irinotecan and cetuximab or panitumumab? ❑ Yes ❑ No

13. What is the place in therapy in which the requested drug will be used?
    ❑ Primary treatment ❑ Subsequent treatment

14. What is the clinical setting in which the requested drug will be used?
    ❑ Unresectable metachronous metastases
    ❑ Unresectable advanced disease
    ❑ Metastatic disease
    ❑ Other _____

15. Which of the following treatments has the patient received within the past 12 months?
    ❑ Adjuvant FOLFOX (fluorouracil, leucovorin, and oxaliplatin)
    ❑ Adjuvant CapeOX (capecitabine and oxaliplatin)
    ❑ Other _____

***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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