PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 5/13/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: **Patient Phone:** **Physician Name:**
_____ **NPI#:** _____ **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the patient's diagnosis?
   - Cutaneous melanoma (If checked, go to 2) ☐
   - Glioma (If checked, go to 2) ☐
   - Meningioma (If checked, go to 2) ☐
   - Astrocytoma (If checked, go to 2) ☐
   - Colon cancer (If checked, go to 2) ☐
   - Rectal cancer (If checked, go to 2) ☐
   - Appendiceal adenocarcinoma (If checked, go to 2) ☐
   - Anal adenocarcinoma (If checked, go to 2) ☐
   - Non-small cell lung cancer (NSCLC) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
2. Is this a request for continuation of therapy with the requested drug? **Y** ☐ **N** ☐
3. Is there evidence of unacceptable toxicity while on the current regimen? **Y** ☐ **N** ☐
4. Is there evidence of disease progression while on the current regimen? **Y** ☐ **N** ☐
5. What is the patient's diagnosis?
   - Cutaneous melanoma (If checked, go to 6) ☐
   - Glioma (If checked, go to 16) ☐
   - Meningioma (If checked, go to 16) ☐

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Astrocytoma (If checked, go to 16) ☐

Colon cancer (If checked, go to 17) ☐

Rectal cancer (If checked, go to 17) ☐

Appendiceal adenocarcinoma (If checked, go to 17)

Anal adenocarcinoma (If checked, go to 17) ☐

Non-small cell lung cancer (NSCLC) (If checked, go to 23) ☐

6. Does the patient have BRAF V600 mutation-positive (e.g., BRAF V600E or V600K mutations) disease? ACTION REQUIRED: If Yes, attach chart note(s) or test results of BRAF V600 mutation status. Yes (If checked, go to 7) ☐

   No (If checked, no further questions) ☐

   Unknown or not available (If checked, no further questions) ☐ACTION REQUIRED: Submit supporting documentation

7. What is the clinical setting in which the requested medication will be used? Unresectable disease (If checked, go to 8) ☐

   Metastatic disease (If checked, go to 8) ☐

   Neoadjuvant therapy (If checked, go to 13) ☐

   Adjuvant therapy (If checked, go to 10) ☐

   Limited resectable local satellite/in-transit recurrent disease (If checked, go to 11) ☐

   Other, please specify. (If checked, no further questions) ☐

   _____

8. Will the requested medication be used in any of the following regimens? In combination with binimetinib (Mektovi) (If checked, no further questions) ☐

   Single agent (If checked, go to 9) ☐

   Other, please specify. (If checked, no further questions) ☐

   _____

9. Is BRAF/MEK inhibitor combination therapy contraindicated? **Y** ☐ **N** ☐

10. Does the patient have resected stage III disease? **Y** ☐ **N** ☐

11. Will the requested drug be used in combination with binimetinib (Mektovi)? **Y** ☐ **N** ☐

12. Has the patient had an unacceptable toxicity to therapy with dabrafenib (Tafinlar) in combination with trametinib (Mekinist) or dabrafenib/trametinib are less desirable based on side-effect profiles? **Y** ☐ **N** ☐

13. Will the requested drug be used in combination with binimetinib (Mektovi)? **Y** ☐ **N** ☐

14. Is immunotherapy contraindicated? **Y** ☐ **N** ☐

15. Has the patient had an unacceptable toxicity to therapy with dabrafenib (Tafinlar) in combination with trametinib (Mekinist) or dabrafenib/trametinib are less desirable based on side-effect profiles? ☐ **Y** **N**

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16. What is the patient's BRAF V600 mutation status (e.g., BRAF V600E or V600K)? ACTION REQUIRED: If Positive, attach chart note(s) or test results of BRAF V600 mutation status. Positive (If checked, no further questions) ☐

    Negative (If checked, no further questions) ☐

    Unknown or not available (If checked, no further questions) ☐ ACTION REQUIRED: Submit supporting documentation

17. What is the patient's BRAF V600E mutation status? ACTION REQUIRED: If Positive, attach chart note(s) or test results of BRAF V600E mutation status.

    Positive (If checked, go to 18)

    Negative (If checked, no further questions) ☐

    Unknown or not available (If checked, no further questions) ☐ ACTION REQUIRED: Submit supporting documentation

18. What is the requested regimen?

    In combination with either cetuximab (Erbitux) or panitumumab (Vectibix) (If checked, go to 19) ☐

    In combination with FOLFOX (fluorouracil, leucovorin, and oxaliplatin) regimen and either cetuximab (Erbitux) or panitumumab (Vectibix) (If checked, go to 22) ☐

    Other, please specify. (If checked, no further questions) ☐

    _____

19. What is the place in therapy in which the requested medication will be used? Primary treatment (If checked, go to 21) ☐

    Subsequent therapy (If checked, go to 20) ☐

    Other, please specify. (If checked, no further questions) ☐

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20. What is the clinical setting in which the requested medication will be used?

    Advanced disease (If checked, no further questions) ☐

    Metastatic disease (If checked, no further questions) ☐

    Other, please specify. (If checked, no further questions) ☐

    _____

21. Will the requested medication be used for unresectable metachronous metastases and the patient has received FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin) within the past 12 months? **Y** ☐ **N** ☐

22. What is the clinical setting in which the requested medication will be used?

    Unresectable disease (If checked, no further questions) ☐

    Medically inoperable disease (If checked, no further questions) ☐

    Metastatic disease (If checked, no further questions) ☐

    Other, please specify. (If checked, no further questions) ☐

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23. What is the patient's BRAF V600E mutation status? ACTION REQUIRED: If Positive, attach chart note(s) or test results of BRAF V600E mutation status.

- Positive (If checked, go to 24) ☐
- Negative (If checked, no further questions) ☐
- Unknown or not available (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

24. What is the clinical setting in which the requested medication will be used?

- Recurrent disease (If checked, go to 25) ☐
- Advanced disease (If checked, go to 25) ☐
- Metastatic disease (If checked, go to 25) ☐
- Other, please specify. (If checked, no further questions) ☐

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25. Has the patient experienced disease progression on BRAF-targeted therapy? **Y** ☐ **N** ☐ ☐

26. Will the requested medication be used in combination with binimetinib (Mektovi)? **Y** **N**

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date