CAREFIRST COMMERCIAL - NON-RISK - SPC

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS Caremark at 866-249-6155. Please contact CVS Caremark at 866-814-5506 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Cotellic

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 diagnosis?

   - Astrocytoma (If checked, go to 2) ☐
   - Cutaneous melanoma (If checked, go to 2) ☐
   - Glioma (If checked, go to 2) ☐
   - Histiocytic neoplasms (Erdheim-Chester disease, Langerhans cell histiocytosis, Rosai-Dorfman disease) (If checked, go to 2) ☐
   - Meningioma (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 medication? **Y** ☐ **N** ☐

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐

4. What is the diagnosis?

   - Astrocytoma (If checked, go to 12) ☐
   - Cutaneous melanoma (If checked, go to 5) ☐
   - Glioma (If checked, go to 12) ☐
   - Histiocytic neoplasms (Erdheim-Chester disease, Langerhans cell histiocytosis, Rosai-Dorfman disease) (If checked, go to 13) ☐

Meningioma (If checked, go to 12) ☐

5. In which of the following settings will the requested medication be used?

Unresectable disease (If checked, go to 10) ☐
Metastatic disease (If checked, go to 10) ☐
Neoadjuvant treatment (If checked, go to 7) ☐
Adjuvant treatment (If checked, go to 6) ☐
Limited resectable local satellite/in-transit recurrent disease (If checked, go to 8) ☐
Other, please specify. (If checked, no further questions) _____

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

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

8. 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** ☐

9. Will the requested medication be used in combination with vemurafenib (Zelboraf)? **Y** ☐ **N** ☐

10. In what regimen will the requested medication be used?

In combination with vemurafenib (Zelboraf) only (If checked, go to 11) ☐
In combination with vemurafenib (Zelboraf) and atezolizumab (Tecentriq) (If checked, go to 11) ☐
In combination with vemurafenib (Zelboraf) and atezolizumab and hyaluronidase-tqjs (Tecentriq Hybreza) (If checked, go to 11) ☐
Other, please specify. (If checked, no further questions) _____

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

Yes (If checked, no further questions) ☐
No (If checked, no further questions) ☐
Unknown (If checked, no further questions) ☐

12. What is the patient's BRAF V600 mutation status (e.g., BRAF V600E or V600K)? ACTION REQUIRED: Please 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) ☐

13. Will the requested medication be used as a single agent? **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.

_____

Prescriber (Or Authorized) Signature and Date