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) ☐
   - Langerhans cell histiocytosis (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 medication? **Y** ☐ **N** ☐
3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen? **Y** ☐ **N** ☐
4. What is the patient's diagnosis?
   - Cutaneous melanoma (If checked, go to 5) ☐
   - Glioma (If checked, go to 17) ☐
   - Meningioma (If checked, go to 17) ☐
   - Astrocytoma (If checked, go to 17) ☐
   - Langerhans cell histiocytosis (If checked, go to 18) ☐
   - Non-small cell lung cancer (NSCLC) (If checked, go to 19) ☐

5. Does the patient have NRAS-mutant melanoma? ACTION REQUIRED: If Yes, attach chart note(s) or test results of NRAS mutation status. Yes (If checked, go to 6) ☐

   No (If checked, go to 9) ☐

   Unknown (If checked, go to 9) ☐

   ACTION REQUIRED: Submit supporting documentation

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

   Metastatic disease (If checked, go to 7) ☐

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

   _____

7. Which of the following applies to the patient's disease? The patient is previously untreated (If checked, go to 8) ☐

   The patient has experienced disease progression on or after prior immunotherapy (If checked, go to 8) ☐

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

   _____

8. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

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

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

    Unresectable disease (If checked, go to 13) ☐

    Metastatic disease (If checked, go to 13) ☐

    Neoadjuvant therapy (If checked, go to 14) ☐

    Adjuvant therapy (If checked, go to 11) ☐

    Limited resectable local satellite/in-transit recurrent disease (If checked, go to 12) ☐

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

    _____

11. Does the patient have resected stage III disease? **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. Does the patient have BRAF 600 activating mutation (e.g., V600E or V600K)? ACTION REQUIRED: If Yes, 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 or not available (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

14. Does the patient have BRAF V600 mutation-positive disease? ACTION REQUIRED: If Yes, attach chart note(s) or test results confirming BRAF V600 mutation status.

Yes (If checked, go to 15) ☐

No (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation ☐

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

16. 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**

17. 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

18. Will the requested medication be used as a single agent? **Y** ☐ **N** ☐

19. 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 20) ☐

Negative (If checked, no further questions) ☐

Unknown or not available (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

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

Recurrent disease (If checked, go to 21) ☐

Advanced disease (If checked, go to 21) ☐

Metastatic disease (If checked, go to 21) ☐

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

_____

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

22. Will the requested medication be used in combination with encorafenib (Braftovi)? **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